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Many elementary school children in the disadvantaged areas of Boston manifest serious emotional and behavioral problems which hinder their performance in school and often negate the value of the school's educational program. Factors in the home and neighborhood environment often cause problems such as antagonistic behavior in school, abusiveness to other students, lack of respect for authority, aggressive and hyperactive behavior, temper tantrums, sadism, and obscenity before peers and teachers. In the upper elementary grades, such children tend to be truants and to appear frequently in courts on charges relating to delinquency acts.

A pupil adjustment counseling program has existed in Boston for some years. Pupils are referred only through the principal, and the number of students assigned to each counselor is about 15,000. Both the established and the experimental school Adjustment Counseling Programs focus on the identification and treatment of behavioral and other personal problems which interfere with a child's learning process or with the learning of other children associated with him.

The experimental program provides a much smaller ratio of students to counselor. This should make possible service for more children, earlier detection and treatment, and more frequent contact with families of the children and community agencies. Pupils will be referred directly to the counselor by teachers. Closer contact between teachers and adjustment counselors will enable teachers to deal with some behavioral problems and troublesome situations in the classrooms themselves. The typology manual which is included contains descriptions of problems, and procedures to be followed by the counselor in working with teacher, child, parents, and other special resources. A research design for an evaluation of the program is given. By comparing experimental with control groups, the evaluation should determine the amount of change due to both the small counselor-student ratio and the new referral system.

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FOURTH DRAFT

EXPERIMENTAL SCHOOL ADJUSTMENT COUNSELOR PROGRAM IN THE BOSTON PUBLIC SCHOOLS

PROGRAM AND RESEARCH DESIGN

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THE PROBLEM

Many elementary school children in the disadvantaged areas of Boston manifest serious emotional and behavioral problems which hinder their performance in school and often negate the value of the school's educational program.

These children are victims of a home and neighborhood environment which causes problems with which the classroom teacher cannot and often should not deal. That environment may be a broken home caused by death or desertion; a home where prolonged physical or mental illness causes the absence of a parent; a home where parents quarrel violently or where there is excessive drinking; a home where both parents work a great part of the week and give insufficient attention to the needs of their children. Such factors are frequently associated with inconsistent upbringing, poor models for identification, and devaluation of educational goals for the child.

Children from these families often show antagonistic behavior in school, abusiveness to other students, lack of respect for authority, aggressive and hyperactive behavior, temper tantrums, sadism, and obscenity before peers and teachers. In the upper elementary grades, such children tend to be truants and to appear frequently in court on charges relating to delinquent acts.

Additional problems exist among in-migrant children entering the public schools at various grade levels. These children come to Boston most often from Southern rural areas, Puerto Rico, Cuba, and less often from foreign nations. Their problems of acculturation are intense; and, in instances of emotional problems, their difficulties are multiplied.

EXISTING PROGRAM[1]

The Pupil Adjustment Counseling Program was initiated in Boston in 1945 to deal with the problems cited above. It was designed "to assist in the study and correction of pupils with behavioral, personality or maladjustment problems.[2]

The program was handled by a small staff until 1955, when it became possible to take advantage of State financial assistance for local School Adjustment Counselor Programs. The state law enabled the Boston Public Schools to double its pupil adjustment counselor staff, and by 1963 there were ten adjustment counselors in the school system.

The existing program has a director, a staff of ten adjustment counselors, and a research assistant. Each adjustment counselor in Boston is assigned to a geographical area, with one school in that area designated as his base of operations. The counselor is required to visit the other schools in his geographical district at least once every two weeks. The principal of each school district is the only person who refers students to the adjustment counselor. The principal consequently determines both the number and the kinds of problems that will be referred to the adjustment counselors.

Information on the 1962-63 workload of school adjustment counselors is presented in the following table:

Counselor	No. of Schools Covered Elem.	No. of Schools Covered Jr. High	No. of Pupils in Assigned Schools	Average Monthly Caseload	Total Number of Cases Served During Year
A		8	12,322	61	90
B	6	8	10,630	48	75
C	25		10,431	37	60
D	29		11,215	40	65
E	19		9,351	62	90
F	18		6,314	47	75
G	19		8,003	60	90
H	25		8,154	49	75
I	17		5,388	80	120
J	23		11,645	58	90

---

[1] Operated in the Boston Public Schools by the Division of Pupil Adjustment Counseling. The term "School Adjustment Counselor" was introduced by state law in 1955.

[2] Boston Public Schools, Special Services in the Boston Public Schools, School Document, No. 9, 1962.

The time allocated to individual cases varies from a few months to an entire school year. While all cases technically are closed at the end of the school year, some are closed with the intent of being re-opened in September.

A report from the Head of the Division of Pupil Adjustment Counseling covering the types of cases referred shows that the behavior problems referred most frequently are: (a) temper tantrums and swearing; (b) biting, kicking and fighting; (c) hyperactivity and destructiveness; (d) truancy and other misbehaviors; (e) defiance and unruliness; (f) learning problems; and (g) adolescent rebelliousness.

Referred children are very frequently characterized by: (a) violent behavior attributed to a sudden death in the family or parental desertion; (b) non-school attendance and school phobia; (c) cheating; (d) stealing; and (e) lying.

Referred often is the child who: (a) uses obscene language; (b) appears neglected; (c) cannot share; (d) is depressed; (e) is a bully or over-boastful; (f) is sneaky; (g) is unusually shy; (h) is over-controlled or over-polite; and (i) is accident prone.

Referred sometimes is the: (a) isolate; (b) whining, crying child; (c) fire-setter; (d) sexual deviate; (e) runaway; (f) stutterer; and, (g) baby-talker.

Referred rarely is the child who: (a) is not toilet trained; (b) assaults his teacher; and (c) drinks alcoholic beverages.

School adjustment counselors are assigned to populations ranging from 5,000 to 12,000 children and are responsible for from 8 to 29 schools. Under these conditions it is reasonable to assume that the available counseling service has not been able to meet the need for such services in any one school. Therefore, teachers tend to refer, through their principals, only those youth whose behavior is extreme and noticeable. Because the counselors must serve large territories and populations, they devote considerable time to traveling and are forced to deal mainly with "emergencies" and "crises". As a consequence, no school is served in depth.

THE EXPERIMENTAL PROGRAM

Both the established and the experimental School Adjustment Counseling Programs focus on the identification and treatment of behavioral and other personal problems which interfere with a child's learning process or with the learning of other children associated with him.

The success or failure of the experimental School Adjustment Counseling Program will be judged in terms of the extent to which it:

1. Improves the academic school performance of children referred to the program.
2. Improves the academic school performance of children attending class with the referred children.
3. Improves the school behavior of children referred to the program.
4. Improves the school behavior of children attending class with referred children.

Assumptions

ABCD and the office of Pupil Adjustment Counseling in the Boston School Department have developed an experimental program based on the following assumptions:

1. That closer and more direct contact through consultation between teachers and school adjustment counselors will provide opportunities for teachers to make use of the skills of the school adjustment counselors more effectively. The teachers themselves will be helped to handle troublesome situations which interfere with the teaching-learning process for students in their classes. Thus, fewer students may have to be referred.

   This more informal and more frequent interaction between teachers and school adjustment counselors will have other effects. Youngsters who are not referred or discussed will benefit from the service either because the teacher is able to deal with their behavior problems more effectively or because the classroom is disrupted less often and is more conducive to learning.

2. That in any one school or classroom more students in need of adjustment counseling will be referred. It is assumed that as more children are served by the counselor, the entire classroom and school are helped.

3. That the experimental program will be more effective with referred cases than is the present program.

   The assignment of school adjustment counselors to a considerably smaller population and geographic area will reduce the time and energy now lost in traveling among schools. In addition, the counselor's daily availability to a limited number of students and teachers will make possible:

   a. Earlier detection and treatment of problems.
   b. More frequent contact with the referred children and their families.
   c. More frequent and systematic relations with other community agencies and resources serving youth and adults.

4. That some of the behavior problems potentially leading to failure in the school and community cannot be diagnosed or treated under the limitations of the present program. These problems are less disruptive in the classroom than those now referred to the counselors. They may prove to be just as critical in the long run, however, if nothing is done about them. The experimental program will affect more of these problems than the present program and will improve the performance of both referred and non-referred children.

Description of Program

The experimental program provides a school adjustment counselor for each of three elementary school districts and one school adjustment counselor for a junior high school. Two of the elementary school districts are in Roxbury and one is in the South End. The junior high school is in Roxbury.

In the experimental program the four school adjustment counselors will be under the direct administrative supervision of the Head of Pupil Adjustment Counseling, who will share responsibility for the implementation of the program with ABCD's program development and evaluation staffs.

The general procedures to be followed in the experimental program are as follows:

1. The school adjustment counselor will work with selected classroom teachers to develop and maintain a system of direct referrals in the PAC's base school. Traditionally, all referrals must come from the teacher to the principal, who then decides whether the case should be handled by the school adjustment counselor.
2. The school adjustment counselor will act as a consultant to classroom teachers, principals, guidance counselors, attendance officers, and other school personnel regarding behavioral problems.
3. The school adjustment counselor will develop an intensive diagnosis of referred cases. Where appropriate, he will develop relationships with the children and their families in order to help in the provision or acquisition of other necessary services.
4. In cooperation with local public and private resources, the school adjustment counselor will develop a systematic and coordinated network of agency interactions and case referrals.

The following typology of problems ranked by priority for treatment has been developed for teachers to use in making a referral and for counselors to use in refining their diagnoses:

1. Kindergarten

Priority A

(1) Temper tantrums and screaming

(2) Biting and kicking

(3) Hyperactivity and uncontrollable striking at others; unnecessary disturbances in the classroom by slamming desks, throwing books on floor, etc.

(4) Violent behavior changes attributable on diagnosis to severe change in family picture; e.g. death or desertion of key figures

Priority B

(1) Incomplete toilet training and nausea

(2) Non-school attendance (including school phobia)

Priority C

(1) Obscenity of language

(2) Neglect by family, evidenced by severely malnourished appearance, inadequate clothing for weather, dirty appearance, lice in hair, lack of lunch or milk

(3) Inability to share

(4) Difficulty with basic class discipline

(5) Continuous clinging to the teacher

(6) Excessive cuteness (may become exhibitionism)

(7) Bizarre or morbid fabrication (stories involving death, blood, killing, hatred, violence, etc.)

Priority D

(1) Isolation - characterized by muteness, inability to participate in groups, daydreaming, genital grabbing or manipulation, nail-biting, appearance of constant anxiety; over-reaction to situations with fearfulness or trembling

Priority E

(1) Whining, crying, fretting, thumbsucking

(2) Stuttering

(3) Lisping

2. Grades One through Three

Priority A

(1) Persistence of any previously described symptoms

(2) Fire setting

(3) Open obscenity in language and behavior

(4) Lewd mannerisms, unprovoked sexual behavior toward same or opposite sex, clutching genitals, possession of obscene pictures

Priority B

(1) Truancy (more than occasional)

(2) Prolonged or continued absence from home (including the runaway)

(3) Stealing (environmentally induced)

(4) Stealing (pathologically derived)

(5) Lying, cheating (environmentally induced)

(6) Lying, cheating (pathologically derived)

(7) Depression

(8) Defiance of teacher's authority

(9) Exhibitionism

Priority C

(1) Bullying other children, excessive boasting; domineering, over-aggressive control of others

(2) Slyness, underhanded, generally untrustworthy behavior

(3) Defiance, unruliness; disrespectful attitude, uncontrolled swearing

Priority D

(1) Learning problems -- when it is diagnostically clear that behavior bears directly on slowness of learning

(2) Excessive shyness, blushing, inability to participate in oral reading

(3) Overcontrol and self-restraint, over-politeness, excessive fear of authority

(4) Accident proneness--continuous physical injury

3. Grades Four through Six

Priority A

(1) Persistence of any previously described symptoms

(2) Direct assault upon teachers, with and without weapons

(3) Drinking of alcoholic beverages

(4) Continuous fist-fighting

Priority B

(See Grades One through Three)

Priority C

(1) Stubborn behavior--more deeply rooted than earlier defiant behavior, coupled with surliness and uncommunicativeness

Priority D

(See Grades One through Three)

4. Grades Seven through Nine

Priority A

(1) Persistence of any previously described symptoms

Priority B

(See Grades One through Three)

Priority C

(1) Excessive adolescent rebelliousness: attempt to challenge discipline or control; stubborn, defiant behavior, freshness; this behavior can account for some forms of truancy, if there is not a previous history of truancy

Priority D

(See Grades One through Three)

The manual, which begins on Page 14, contains descriptions of problem etiology and describes the procedures to be followed by the school adjustment counselor in working with the teacher, the child, the parents and other special resources. These step-by-step procedures are to be followed from the point of case detection to case termination as an integral part of case management and case supervisory procedure.

The following steps will be followed by the experimental school adjustment counselors in the experiment; as each step is made in a case, it will be recorded and documented by the school adjustment counselor:[1]

1. Detection of Problem (How the child is brought to the attention of the school adjustment counselor):
   While the teacher in selected classrooms discusses referrals directly with the school adjustment counselor, she also fills out a referral card on which she writes the name of the child, the class, and her reason for referring the child. In the base schools where there is direct communication between school adjustment counselor and teacher concerning referrals, it is the responsibility of the school adjustment counselor to bring such cards to the principal for his signature. In this manner, although the principal no longer determines who shall be referred in those selected classrooms, he is kept informed of all referrals taking place in his school.

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[1] The forms used by the school adjustment counselor for recording and documenting the steps outlined here are included in the appendix of this document.

2. Preliminary Investigation of the Referral:

After detection, the school adjustment counselor will supplement the teacher's written and stated comments with additional information such as any social agencies he might have contacted, classroom or other observations he may have made himself or which were described to him by others, and a review of the student's cumulative record. He will then fill out a detailed check list of all the information received from the sources previously identified.

3. Delineation of Problem:

The school adjustment counselor will then write a description of the problem as he defines it after he has completed the preliminary investigation. His description of the problem may be similar to or different from that which is described by the referring teacher. In the event that there is a difference in the two descriptions, the school adjustment counselor will clarify this in his continued contact with the teacher.

4. Recommendations:

The school adjustment counselor prepares a written recommendation as to what he considers to be the next step. This may be:

a. The case is not appropriate for referral to the school adjustment counselor. (This may occur in situations where a child is described by teacher as a "bad boy", and the teacher wishes the counselor to discipline him.)

b. The case will be held for observation only

c. The case requires consultation with the teacher only

d. Specific activities should begin; e.g. contact with the child, contact with the home, etc.

Following this written recommendation, the school adjustment counselor will discuss his recommendations with the supervisor.

If (a) the case is considered inappropriate, the school adjustment counselor will notify the teacher and will help the teacher decide what needs to be done about the situation.

Recommendations - Continued

If (b) the case is to be held for observation, the school adjustment counselor will convey to the teacher that there will be a waiting and watching period to learn more about the child's behavior.

If (c) there is to be consultation with the teacher only, the school adjustment counselor will begin discussions with the teacher.

If (d) specific activities can begin, the school adjustment counselor will begin the preliminary activities. These may include contact with the child, contact with the parents. These preliminary contacts will provide further diagnostic information to the school adjustment counselor. After contact with the home and child, the school adjustment counselor will take the next steps. These may include:

(1) A decision to refer the child for physical examination (this decision may be made prior to extended home visits or contact with the child)

(2) Referral of the child for psychological testing

(3) Referral of the child to other resources within the school system; e.g., special class, eye conservation class, remedial reading class, etc.

While following these possible courses of action, the school adjustment counselor may continue to work with the child and the parents. Other possible courses of action may include referral of child to:

(1) A child guidance clinic

(2) A group work agency

(3) A family service agency (along with members of the family)

(4) Other agencies

5. Case Action and Recording:

If the decision is to activate the case, the school adjustment counselor will note this. A record of case progress will be initiated. This record will include a continuous accounting of all visits made and a brief description of what occurred during these contacts and any other steps taken around case management.

6. Progress Assessment:
   a. The school adjustment counselor will continuously evaluate with the teacher the child's progress, behavior changes, etc.
   b. From time to time the supervisor and school adjustment counselor will meet and evaluate case progress. If necessary, replanning will take place if case findings up to that point indicate such need.
   c. The progress assessment conferences will also be utilized to determine at what point the case shall be terminated and the reason for termination shall be given.
7. Periodic Re-check after Termination:

   Forms have been developed which will provide for follow-up-data regarding progress of the child after the case has been terminated.

A. KINDERGARTEN

PRIORITY A

1. (108) Symptoms: Temper Tantrums and Screaming

(a) Causations - This is generally in the form of an outburst or impulsive behavior. Some of the possible explanations include excessively sadistic discipline by parents, and imitation of rageful behavior by parents in the home. Additionally, this behavior may be attributed to alternating patterns of discipline in the home (e.g. excessive indulgence countered by excessive punishment). Also this behavior may be child's learned reaction to continued and intense frustration of his wishes and/or needs. It may be the onset of serious illness. In some instances, it may be attributable to brain damage.

(b) General Observations - These symptoms are rarely transitory. They are recognized by their over-reactive quality; thus, reactions to frustration which do not upset or only mildly upset most children cause this child to have a violent temper tantrum. The screaming is usually inappropriate and not related to a particular situation; it contains an unreal quality as if the child is responding to something within himself. Continuous outbursts indicate that this child should be reported to the Pupil Adjustment Counselor.

(c) Pupil Adjustment Counselor Involvement - Crucial and immediate. In addition to serving as an additional person to help control the child in the school setting, the Pupil Adjustment Counselor will begin a diagnostic, planning, and management and treatment program. Included in the first steps in diagnosis should be a comprehensive physical examination.

(d) Home Involvement - Mandatory via Home Visiting - In addition to obtaining the child's early history, a relationship should be established with the parents leading toward the development of a management and treatment program for the child. Their cooperation will be required in the extensive physical

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* This Typology Manual has been the work primarily of Edward Stone.

examination program which also is advised. Over a period of time they should be made aware of the seriousness of the child's problem if the symptoms are persistent. This is especially true if early diagnosis reveals one or more of the factors outlined under (a) in this section. While elaboration of the process of work with parents is not detailed here, it will be crucial to recognize differential diagnostic issues with parents -- possibly regarding schizophrenia.

(e) Other Agency Involvements - If this is a persistent symptom, other agencies will need to become involved. The type of agency services to be utilized will depend on the apparent source of the difficulty -- i.e. whether it is basically physiological or psychological. When these kinds of problems are persistent, they probably are best handled in a child guidance clinic setting. The value of psychiatric handling for the child is that it provides the combined neurological-psychological service that may be required, including drug therapy if indicated.

(f) Observations - Pupil Adjustment Counselors should not be lulled into a false sense of security with this kind of child if the symptoms are intense at any point and then disappear. This kind of child should be watched for the possibility of other kinds of either physiologically or psychologically induced outbreaks.

2. (110) Symptoms: Biting and Kicking

(a) Causations - If these actions are persistent and resemble primitive-like behavior, their etiology is similar to that of the "temper-tantrum/screaming" group. Of special concern with this group is the possibility that the biting, if severe, can be evidence of schizophrenia or retardation.

(b) General Observations - Kicking as an isolated symptom may not be quite as serious: it may be the child's learned reaction to stress -- i.e. self-defense in what he perceives to be a threatening situation. If he has learned that kicking with a booted foot more nearly immobilizes his opponent, he is apt to use this method of striking at people. Biting is generally attributed to more primitive methods of expressing aggression and is therefore considered the more serious symptom.

(c) Pupil Adjustment Counselor Involvement is crucial and immediate. His role is similar to that for the "temper-tantrum/screaming child".

(d) Home Involvement - Mandatory via Home Visiting. - This is applicable as in the previously described symptom.

(e) Other Agency Involvement - This is possibly less a concern with the kicking child, if Pupil Adjustment Counselor, teacher and home involvement combination is effective in reducing both the aggressive drive behind the symptom and the child's need to attack or defend himself in this way. The biting symptom is considered more serious, and contact with other agencies should follow the same approach as outlined for the previous symptom group.

(f) Summary Contents - Both the "temper-tantrum/screaming" and "biting/kicking" children inevitably place the teacher in the classroom or in the schoolyard in an undesirable and over-aggressive role in order to bring the behavior under control. Teachers generally are reluctant to be viewed in this over-aggressive role; nor do they feel, rightfully, that having to deal continuously with such children contributes anything to the group's learning experience. Such cases should not have to be handled in the classroom or school setting for any prolonged period of time. If the behavior persists after all reasonable efforts at control have been attempted, other kinds of planning for the child should be instituted. This may include removal from the school setting.

3. (112) Symptoms: Hyperactivity and uncontrollable striking at others; unnecessary disturbances in the classroom by slamming desks, throwing books on floor, etc.

(a) Causations - There is a need to examine the child's behavior along relatively similar lines as described for the previous symptom.

(b) General Observations - This type of symptom rarely is transitory. However, if it is in direct reaction to great stress from the home because of a specifically difficult situation, it may subside if the stress is reduced. This child may be hyperactive without manifesting destructive qualities and may sometimes find an appreciative audience for his behavior -- even at times with teachers who do not find the hyperactivity particularly distressing. In these instances, careful and extensive diagnosis is important since the child's behavior may be clouded over, because he is a particularly "sweet" or "charming" youngster. He is not to be confused with the normally "more active" or somewhat "more aggressive" youngster who still functions within a range that is controllable by teachers.

(c) Pupil Adjustment Counselor Involvement is Mandatory. - It is necessary to diagnose the child's behavior and help him control his behavior. A physical examination is also an important component in this diagnosis.

(d) Home Involvement -- Required. The causes of hyperactivity should be determined through home investigation. If necessary, management and treatment should be planned with parents. This is more urgent in direct relationship to the child's destructive behavior. Hyperactivity coupled with property destruction usually is indicative of loose controls from the home. Often parents will complain they simply "can't manage Johnny".

(e) Other Agency Involvement - This depends very much on the diagnostic picture. A child guidance clinic is recommended if the child's hyperactivity is seen as deeply rooted in the child's general behavior pattern. It is possible that a referral of this type of youngster's parents to a social work agency can produce the desired results with the child, if the parents are amenable to this kind of help and can learn through it how better to handle and react to the child.

In general, the three groups of symptoms described under Priority A indicate a high component of aggression in the child. This can range from a child who shows relatively more aggression than his class in general, through various levels of hostility, to outright rage -- which in its most pathological form has qualities of being murderous. It is important to remember that such children provoke counter-aggression in adults who feel that their authority is being challenged, and whose first impulse often is to quell the child's aggressiveness. There is no question that the child's aggression needs to be brought under control, both for the child's sake, for the sake of those around him, and for the sake of those who need to deal with him. The methods used will depend on how much anxiety the child's behavior engenders in those around him, but the more quietly and firmly the behavior is handled, the more effective will be the results. These classifications do not describe all of the ways in which children can express hostility or aggression, but they do cluster because the aggression is thrust outward by the child and very often should be coped with immediately and directly.

4. (114) Symptoms: Violent behavior changes attributable on diagnosis to severe change in family picture: e.g., death or desertion of key figures.

(a) Causations - A child who previously manifested no or minor difficulties may be faced suddenly with the untimely death of one or another parent; he may be faced with a separation or divorce occurring between parents; or he may be faced with the abrupt, prolonged desertion of one or another parent. All these predicaments may occur with or without forewarning. Thus, this category also includes behavior changes attributable either to severe illness requiring hospitalization of either parent, or to prolonged quarreling between parents leading to separation or divorce. Other causes may include the prolonged illness and death of a grandparent, sibling, or the sudden death of a close relative, an older sibling's running away from home, being ejected from the home, or being removed from the home by legal process.

The behavior changes may take several forms. It is suspected that children's problem or-symptom-expressions follow pathways along which parents unconsciously push the child; or pathways which are consciously or unconsciously made permissible; or perhaps a combination of both. The key factor in diagnosing this particular category is observation of a change from behavior which did not interfere with the educational and social adjustment of the child in school to behavior that does interfere. This includes grades dropping unaccountably, a change in social relationships, crying, inattention, daydreaming, preoccupation, extreme nervousness, irritability, and defiance of school rules.

(b) General Observations - It is crucial to keep in mind a general finding that children at the earliest ages develop a sense of having had something to do with the death, desertion, separation, or divorce of their parents or grandparents. This may also be true in the case of the death or desertion or the ejection or removal of a sibling. While there are some differences of opinion as to the age at which children experience feelings of guilt, there is little question that children feel the impact of, and anxiety around, such losses; and certainly by the time they have reached school age, they are capable of blaming themselves for what happened, even though this may not be conscious, or something the child can articulate.

(c) Pupil Adjustment Counselor Involvement - An initial contact with the child may precede the home visit. The purpose of this initial contact is to explore with the child what may have occurred at home. Depending on factors such as age, ability to trust, or ability to comprehend and articulate the problem, the child may or may not be able to provide the counselor with the necessary information.

The follow-up contact with the child after a home visit will revolve around the Pupil Adjustment Counselor's informing the child that he knows of the difficulty and is prepared to help the child by being an interested and concerned adult with whom the child can talk.

(d) Home Involvement is mandatory. The parent(s) should be contacted (in the case of a death, after an appropriate delay). The Pupil Adjustment Counselor can explore ways in which the parent(s) may help the child deal with this situation.

(e) Other Agency Involvement - If the child does not return to his former level of academic or social functioning within a reasonable period of time (a month or two), consideration should be given to a diagnostic evaluation for the child, or consultation with appropriate persons. Depending on the particular circumstances, this situation may require assistance from a child guidance clinic or another social agency. The Pupil Adjustment Counselor should not attempt depth treatment.

PRIORITY B

1. (118) Symptoms: Incomplete Toilet Training and Nausea

(a) Causations - Each of the two symptoms should be further sub-divided for explanations of causation. However, generally each of the two, or a combination of the two, may appear briefly in this age group of children in the first days or even weeks of the school experience. This can be attributed to separation from mother and/or to fear of a new experience. In the case of the child who shows loss of bowel control or wetting, it needs to be determined whether this is a regression. Our culture normally expects children to be trained by age three. If a previously trained child becomes incontinent upon entering school, this regression usually can be attributed to the child's fears about school.

This also can apply to a brief period of gagging or vomiting. However, if the bowel training is something which has never been adequately dealt with at home, two areas should be considered. One area is a family in which cultural disadvantage is great or the simplest basic knowledge about training is absent or haphazard. In extreme instances these parents may be mentally retarded. The other area which may be manifesting itself is more pathological and indicates that the parents and the child have been fighting with each other about bowel training. This child's continued failure to become bowel trained usually means that he is attempting to strike back at his parents.

Wetting is a separate symptom which is commonly defined as enuresis and which may be a separate and more prolonged symptom expression. It also is possible that this is a regressive expression of anxiety about the school situation. Here, once again, careful diagnosis is imperative. This kind of child should be checked for kidney problems, although enuresis rarely has any physical causation. As in the case of the bowel training difficulties, wetting can be a pathological expression of hostility between parents and their children.

Vomiting or gagging among children in this age group can be the result of great anxiety or stress about leaving mother for the first time in order to attend school. In its transitory nature it is not a severe symptom, but it may reflect the child's method of handling the food and eating problem. If this behavior persists, it may be the initial symptom of school phobia. Vomiting or gagging can be a way of expressing anger and fear at leaving his mother and unconsciously the child is frightened that mother will not be there when he returns. School phobia often is further complicated by parents who have extreme difficulty in letting the child separate from them.

(b) General Observations - This child should not be punished or isolated. It is extremely important to keep in mind that in some instances, parents have used extremely harsh and repressive methods in their attempts to train the child. This can include beating the child or rubbing his face in urine-soaked sheets in order to encourage self-control. The Pupil Adjustment Counselor's approach to the problem therefore must be careful and comprehensive; generalizations should be avoided.

(c) Pupil Adjustment Counselor Involvement - It may not be necessary for the Pupil Adjustment Counselor to deal with the child directly. If the Pupil Adjustment Counselor feels that he can personally help the child develop control, he should do so. However, the child usually is not helpful as a source of information about his own particular problem(s). Moreover, the involvement of the Pupil Adjustment Counselor can be extremely threatening to the child unless there is a very specific focus. The child is not aware that his behavior is an expression of hostility toward his parents.

If it is determined that fear of school is a major cause, the Pupil Adjustment Counselor can be helpful in allaying the child's fears about the school setting. In this regard direct involvement is useful.

The factors affecting the involvement or absence of involvement of the Pupil Adjustment Counselor are equally applicable to problems of wetting and nausea.

(d) Home Involvement is required via home visiting. The determination of the history of the symptom is crucial to the diagnosis, and the determination of methods of approach will be derived from the involvement of the parents. The specific management of the treatment program will be determined by the final diagnosis of the persistence and seriousness of the problem and the parents' abilities to cope with it.

(e) Other Agency Involvements - If agencies are involved at all (again this will be dependent on the extent and depth of the problem), this involvement may take two possible directions. A social agency contact with casework help may be sufficient to help the parents manage and control the problem. If the problem is more deeply pathological, child guidance assistance may be required, possibly with psychiatric help for the child.

2. (120) Symptoms: Non-School Attendance (including school phobia)

(a) Causations - This is differentiated from truancy which appears later in this Typology Manual for grades one through three and beyond. It is important to understand that non-school attendance among kindergarten children sometimes has the same basis as truancy in the later grades. In spite of the similarities, there is a tendency to be more lenient toward the younger child.

Many possibilities may account for non-school attendance at the kindergarten level. There is increasing awareness of the symptom or syndrome known as school phobia--a condition in which the child appears to be afraid of going to school. When the child is forced into school, he shows great fear, anxiety, and inability to adjust to the program and routine. He often cries a great deal and appears inconsolable, even in response to the most understanding and patient teacher. He often is unable to remain in class for the prescribed period of time. Parents generally handle this situation in two ways, among others. Either they do not force the child to go to school after initial attempts fail, or they persist in forcing the child into school until the major symptoms have been reduced or disappear.

Unfortunately, on the surface the problem leaves the impression that the child is afraid of something in the school setting. Unwittingly, this may cause difficulty between families and school personnel. There is considerable evidence that school phobia reflects the mother's inability to separate from the child.

Subconsciously, the mother herself fears that something will happen to the child and therefore needs to keep the child close to her. The conscientious mother who has this problem is caught between her wish to fulfill her obligation of sending the child to school and her unconscious fears and anxieties about the dangers this presents. Such a mother may say she fears that the child will be hurt or killed by a car while crossing the street, or that the child will be hurt on the playground, etc.

The causes of this behavior are the mother's subconscious hostility toward the child, which may have multiple sources. In essence, the mother fears that her hostility toward the child will cause a bad thing to happen to the child, and she projects this feeling to the outside world, saying a car or some other "agent" will cause injury or death to the child. Unfortunately, the child picks up (subconsciously) the mother's fears, if not her hostility, and in turn becomes fearful and anxious about leaving his mother. Another consequence of the parent's subconscious hostility is the child's fear that his mother wishes to get rid of him. This fear of being "gotten rid of" can be prevalent among children in homes where parents often quarrel and the child feels he is to blame.

Another phenomenon which may produce what appears to be school phobia occurs when a child enters kindergarten at the time that a sibling is born. The child may see the school experience as an attempt to remove him from home (i.e. away from his mother's love), as if the new sibling is preferred. Unfortunately, if a parent has had a somewhat difficult time bringing up the child under discussion, she may indeed use kindergarten as a "dumping place" so she can turn her attention to the next child. The kindergarten child often senses this and reacts accordingly.

(b) General Observations - School phobia, as a factor of non-school attendance, will sometimes produce physical symptoms in the child, so that he appears to be physically ill. Most common among the symptoms are nausea, vomiting, and complaints of knots in the stomach. While a physical examination is necessary in order to rule out physical illness, the symptoms usually are attributable to emotional upset.

To avoid rigid diagnostic thinking, it is imperative to recognize that there may be manifold reasons for non-school attendance. These include families: (1) where there is literally insufficient clothing for the child to be appropriately dressed for inclement or winter weather; (2) where the value of kindergarten or the educational process in general is not given particular emphasis (this is a lesser problem, generally, since kindergarten is considered permissive education); (3) where there is hostility toward the school system as a result of misunderstandings between teachers and parents, which reduces parental incentive to send the child to school; and, (4) where neglect of children exists in the family, or where the parent wishes to send the child to school but is unable to accomplish this.

(c) Pupil Adjustment Counselor Involvement - Direct or first contact with the child is not advised. First contact should be made with the parents in order to determine causes for non-attendance. Careful analysis of the causes will indicate which of the previously described directions should be followed by the Pupil Adjustment Counselor.

(d) Use of Other Resources - If preliminary diagnosis indicates a school phobia or related psychological difficulties, it is imperative that the child and his parents be prepared for referral to a psychiatric resource for further diagnosis and treatment. Counselors should not attempt to utilize the above material in discussions with the parents. Under uncontrolled conditions such interpretations are highly frightening and will produce destructive consequences. The counselor must address himself simply to the idea that there appears to be an underlying problem for which he wishes the child and parent to obtain help, especially at this early age where effective intervention has the greatest potential for alleviating the problem. The counselor should not participate with the parents or the teacher in any punitive attempts to get the child to school if he diagnoses the problem as school phobia. Such measures may indeed produce the desired surface results but will not eliminate the problem; they will ultimately manifest themselves in some other equally serious or more serious form.

If the problem is related to other factors listed under General Observations, the Pupil Adjustment Counselor must decide whether to help the family obtain appropriate clothes or to refer them to an appropriate social agency or other resource. If it is determined that the problem is one of neglect, the Pupil Adjustment Counselor should determine whether appropriate protective services should become involved.

PRIORITY C

1. (124) Symptom: Obscenity of Language

(a) Causations

A child at kindergarten age may use obscene language, at times accompanied by stubborn, defiant behavior, or extreme outbursts of anger. When the language is used without the strong, accompanying effects of anger or temper, it may be part of a language experiment by the child and is primarily a learned reaction to family and environmental language patterns. At this age the child usually does not consider the words particularly forbidden, unless his parents have used the language in his presence and subsequently have chastised him for using the same language. When accompanied by a display of stubborn, defiant behavior or extreme outbursts of anger, the child may still be expressing a learned reaction to stress. The parent(s) may use this method of dealing with stressful situations, and the child may be imitating them in his behavior toward authority figures or systems. At the extreme, obscene language may accompany the symptoms perviously described under temper-tantrums and screaming, biting and kicking; and hyperactivity and destructiveness.

(b) General Observations

Language patterns among youth from culturally disadvantaged neighborhoods are powerfully influenced by environmental factors and do not represent pathological strains. This type of verbal expression from a child in an advantaged environment usually does represent a more centralized level of problem or, at the very least, pathological interactions between parents and their child.

(c) Pupil Adjustment Counselor Involvement

Contact with parents is necessary regardless of the ultimate diagnosis. Direct contact with the child may have varying purposes, and the timing of the contact will be influenced by the Pupil Adjustment Counselor's diagnostic impressions. If the child's use of obscene language is merely an environmentally influenced process, with no special effects attached to it, the Pupil Adjustment Counselor as a role model can utilize his skills in remedying this type of verbalization. The child will respond favorably to an interested, understanding adult. If the child uses obscene language as a learned pattern in association with other symptoms of expressing anger or frustration, the Pupil Adjustment Counselor can influence the child to these patterns through contact with him. This group of children, however, will not benefit greatly from the Pupil Adjustment Counselor's role model assistance unless there is close work with the parents who are stimulating this learned response. When the symptom is associated with the more pathological factors dealt with under temper tantrums and screaming, biting and kicking, hyperactivity and destructiveness, the previously prescribed procedures are applicable.

(d) Home Involvement - Mandatory. - The diagnostic process will require involvement of parents to determine the specific elements stimulating the behavior described above. The intensity of parental involvement depends upon the diagnosis of the source of this behavior.

(e) Other Agency Involvement - The use of additional services depends upon the diagnosis of the source of this behavior. For the child who simply uses obscene language with no attendant symptoms, a community center experience, if available for this age group, can be helpful. A social agency can help parents of the child who is responding to a learned pattern better understand how their behavior affects their child and how the child's behavior can be ameliorated. A referral to a psychiatric resource is suggested if it is determined that the symptom is part of a syndrome related to deeper pathological problems.

2. (128) Symptoms: Neglect by Family, Evidenced by Severely Malnourished Appearance, Inadequate Clothing for Weather, Dirty Appearance, Lice in Hair, Lack of Lunch or Milk, etc.

(a) Causations -

Two major classifications can be generalized for this type of child. He is either in a home where for cultural reasons little awareness of methods of child-rearing exists or where parents are retarded and unable to provide the basic requirements of child care. The latter group also shows patterns of instability around providing appropriate child care, but the reasons for this are much more pathological and the family picture will reveal serious disintegration patterns, alcoholism, chronic unemployment, promiscuity, and severe emotional depression in one or more parents. Psychosis may be evident.

(b) General Observations - Within the generalized groupings above there are several major categories of families which by virtue of their function and behavior are neglecting their children. Differential diagnosis is imperative along with careful exploration of the family situation.

(c) Pupil Adjustment Counselor Involvement - Involvement with the child is usually required except where it is determined that the child may be too frightened or threatened by a direct approach. The Pupil Adjustment Counselor may wish to withhold contact with the child until a home investigation has been made. This is ultimately a matter of management techniques, since a first approach to the child with questions about the home situation may make it more difficult to deal with the parents on follow-up contact. The child may go home and discuss having been questioned, thereby arousing parental defensiveness and creating unnecessary difficulty in communication.

(d) Home Involvement via Home Visiting - This is required immediately. The Pupil Adjustment Counselor should seek information concerning some of the possible causes of neglect and determine with the parents what methods can be utilized in dealing with child's problems.

(e) Other Agency Involvements - This will be as limited or extensive as diagnosis determines. If the diagnosis indicates that this is a home where the parents are simply unaware of basic child-rearing practices, the Pupil Adjustment Counselor may wish to conduct or involve parents in an educational program. If, however, the factors are more complicated and there is evidence of neglect at the level which is relevant to the function of the MSPCC for example, the Pupil Adjustment Counselor may wish to refer this case directly to such an agency. In any event, the Pupil Adjustment Counselor may wish to consult with this agency to determine whether the family situation has reached their attention or whether other social agencies should become involved. It is quite possible that these kinds of families have been known to other agencies, and it may be possible if these past agencies are not active, that they will re-interest themselves in the case on the basis of the symptoms manifested in the school.

3. (144) Symptoms: Inability to Share

(a) Causations - While rarely an isolated symptom in a child, if the inability to share is a predominating symptom, it is usually manifested in a child: (1) who feels deprived at home (this is related to competitiveness with siblings); (2) who has not had sufficient opportunities to develop socialization patterns with peers; (3) who reflects parental attitudes of hostility and who withholds against a depriving world; (4) who had specific difficulties during the bowel training period and who is acting out a withholding pattern in a hostile interaction with his parents.

(b) Pupil Adjustment Counselor Involvement - A preliminary diagnosis is advised before the child is approached. In light of the possible causes of this symptom, there is little if anything to be gained from immediate and direct contact with the child.

Contact with the child following a preliminary discussion with the parents will depend on the results of the diagnostic process. Both the classroom teacher and the Pupil Adjustment Counselor can be of immense direct assistance to the child who feels deprived at home and lacks sufficient opportunities to socialize. Approaches to the child should be more subtle if he is reflecting parent hostility or difficulties stemming from the bowel training period. These latter possible causes require remediation of a more prolonged and intensive nature.

(c) Home Involvement - In all instances, the Pupil Adjustment Counselor will make contact with the home. This is for diagnostic purposes as well as for an opportunity to inform parents of the child's difficulty. If the problems revolve around sibling competition and the child's feelings of deprivation, and if the parents are immediately responsive to this, the Pupil Adjustment Counselor and/or the teachers work with the child and parents may be sufficient. This is also true if the child has not had sufficient socialization opportunities. If the problem derives from the parents' hostility toward the school, the Pupil Adjustment Counselor may work toward amelioration of this difficulty. Here it is important to avoid placing the child in the "middle" of the conflict that may exist between parents and school. Thus, it is recommended that the work with the child in this instance not be intensive. The child will maintain his basic wish to please his parents; therefore the parents' attitudes need to be changed. If the problem is diagnosed as stemming basically from bowel training difficulties, more comprehensive diagnosis will be required for the purpose of determining recommendations for treatment.

(d) Other Agency Involvement - In the instances where problems are related simply to a lack of opportunities for socializatiom, referral to a community center or to a group recreation program can be very productive. If the child feels deprived and intensely competitive with his siblings, the family may need the help of a social agency without direct referral of the child. This is also true for parents who are hostile to the school, if this is an all-pervasive problem of socialization for them. If the parents adjust relatively well to the over-all social system but are having very specific difficulty with the school setting, the Pupil Adjustment Counselor, teacher, and principal may well be able to remedy this problem with the parents.

If the etiology indicates severe bowel training problems, child guidance services should be utilized for further diagnostic and/or treatment procedures.

4. (146) Symptoms: Difficulty with Basic Class Discipline

(a) Causations - If this is primarily an isolated symptom, it may manifest itself by minor infractions of class discipline. The child with this problem is recognized as one who talks out of turn, who sometimes defies the teacher in a moderate way, and who may stimulate others to minor infractions. This child may also be somewhat inattentive, may not complete his homework and thereby irritate his teachers. Such a child most often is seeking attention from his teacher through a negative rather than positive approach. Such behavior can also be a manifestation of the child's fear of being unable to compete scholastically or of an actual inability to compete. It is also possible that the child is transferring problems in his relationship with parents and siblings from the home situation to the classroom setting and that he unconsciously casts the teacher in the role of his parents and his classmates in the role of his siblings. Another possible cause of difficulty with basic class discipline may derive from a home situation where there are negative attitudes toward both school and teachers, or to authority systems in general. The child may be stimulated to act out against these forces.

Differential diagnosis is crucially important in this kind of symptom because difficulty with basic class discipline is also a symptom which may manifest itself in many of the other symptom groups which have been or will be described. If this symptom is isolated in the child, it usually is not internalized and is more amenable to appropriate treatment.

(b) Pupil Adjustment Counselor Involvement - Contact with the child is extremely helpful. The Pupil Adjustment Counselor is in a definite position to act as an understanding and sympathetic adult. He can provide the child with a model who is able to offer some of the additional attention the child may need while assessing what the child's real difficulty is.

(c) Home Involvement - Home visiting is mandatory, since the parents should be notified of the child's difficulties. The Pupil Adjustment Counselor should use the preliminary discussions with parents to diagnose the source of the problem. The extent of prolonged involvement with the parents will depend primarily on the child's response to the direct efforts. It should be reiterated that the ultimate courses of follow-up action will depend on the child's responsiveness to the immediate remedial action taken by the Pupil Adjustment Counselor and/or the teacher.

(d) Other Agency Involvement - Two types of service may be indicated: If the child's problem persists, it may be necessary to seek the diagnostic services of a child guidance setting. On the other hand, this kind of problem may be treated by referring the parents to a social agency and by having the social agency deal with the problem through work with the parents.

5. (148) Symptoms: Continuous Clinging to the Teacher

(a) Causations - This child is usually quite frightened and infantile, often manifesting fears about playing with classmates. This symptom may expand to include whining and crying, and the child may attempt to use the teacher as a protective substitute for his mother. The causations listed for the whining and crying child are applicable here.

(b) Pupil Adjustment Counselor Involvement - See Whining, Crying Symptom

(c) Home Involvement - See Whining, Crying Symptom

(d) Other Agency Involvement - See Whining, Crying Symptom

6. (150) Excessive Cuteness (bordering on or becoming exhibitionism)

(a) Causation - The excessively cute child is often a manipulative youngster who has learned to deal with adults in a charming, semi-seductive fashion. Unfortunately, the child's behavior pattern is flattering and all too acceptable to adults. Its dangers for the child lie mostly in the fact that the child substitutes this behavioral technique for learning to develop and establish more solid kinds of inter-personal relationships. In later years, when the cuteness is inappropriate, the child is bereft of other means of dealing with the socializing process. Such a child usually develops the techniques of excessive cuteness as a way of dealing with a home situation where more direct pathways of giving and receiving are shut off. The child may be identifying with one parent who uses this technique in order to obtain gratification of demands and needs which are not met in a more direct, mature fashion.

(b) Pupil Adjustment Counselor Involvement - This situation can be remedied in part through a relationship with the Pupil Adjustment Counselor and the teacher in which the child is not attacked frontally for this kind of behavior.

(c) Home Involvement - Parents may be less approachable regarding excessive cuteness; they may not see it as a problem. On the other hand, parents may find this behavior extremely irritating and may punish the child or wish the child to be punished. It should be pointed out to parents that the child will encounter difficulty later in life if he continuously demands from others attention which may not be forthcoming. Withholding attention from the child later on will cause him to feel rejected and cast aside.

(d) Other Agency Involvement - Referral to any group experience is appropriate, especially where the leadership is aware of ramifications of the "cuteness" technique for the child. Remedial action should emphasize rewards for straightforwardness by the child.

In the event that the "cuteness" has an irreversible quality about it or is shielding some deeper problems of adjustment, two pathways are open. These are to refer the parents to a social agency or to a child guidance setting for more intensive diagnosis and/or treatment.

7. (152) Symptoms: Bizarre or morbid fabrication

(a) Causations - This symptom, often treated as "lying", consists of stories by the child which appear to the adult as "wild" imaginings. They may or may not contain themes of death, blood, killing, hatred and violence. Children who tell such stories are not lying. Through the "innocent" fabrications or "fairy tales", they are escaping from what they perceive as an extremely difficult situation. They talk about the world they would like to see rather than about the world they are in. Major difficulties for such a child are that the fabrications may appear to become all too real. Unfortunately, if stripped of or denied this mechanism, the child may not be able to deal with what is perceived as an extremely depressing or dangerous situation.

The child who is expressing morbid themes in his fabrications usually has been sensitized by his environment to danger and violence to himself. The child may be expressing both his own aggression, anger, and/or hatred through these themes, and the aggression, anger, and/or hatred he perceives being turned on him, ususally by his parent(s).

The major problem with this type of child is that he may be expressing a serious emotional illness in which the lines between reality and fantasy are blurred. Keeping this in mind, it is of little avail to treat the child as if he can stop this behavior of his own volition. The child may begin to sense at this age that there is something "different" or "queer" about his stories. This feeling should not be reinforced by adults, since the child will soon become aware of this to the point of feeling that he may be "dangerous" or "crazy". In this regard, as he grows older his peers may be able to help him test reality more effectively than adults. However, the symptom is serious and should not be dealt with superficially.

(b) Pupil Adjustment Counselor Involvement - The Pupil Adjustment Counselor will want to establish a relationship with the child for diagnostic purposes and for ultimately helping the child toward a referral source. In the process of determining the range and depth of the problem, the Pupil Adjustment Counselor can subtly engage the child in conversation to determine if he is aware of the difference between reality and his fabrications. Of the two groups, the child who talks of blood, death and violence is potentially more dangerous to himself and/or others. It is questionable whether he is more or less sick than the child who fabricates fairy tales.

(c) Home Involvement - Mandatory. - Parents may try to deny or minimize children's problem. To hide their own anxiety about this, they may express open feelings ranging from concern to anger at the child for having the symptom. Since in its extremes the symptom may reflect a violent and dangerous home atmosphere, the opposite reaction may be expected in some parents.

(d) Other Agency Involvement - Fabrication as a symptom should be psychiatrically diagnosed. In some respects the thinking of youngsters expressing themes of violence closely resembles the patterns of thinking prevalent among fire-setting and assaultive children. Children fond of fairy tales are close to the isolate and his far-ranging world of fantasy.

PRIORITY D

1. (164) Symptoms: Isolation - characterized by muteness, inability to participate in groups, daydreaming, genital grabbing or manipulation, nail-biting, appearance of constant anxiety, and over-reaction to situations with fearfulness or trembling.

(a) Causations - This group of children presents a symptom picture of having "turned inward". The problems which they manifest do not have the outwardly aggressive characteristics of the child prone to temper tantrums or hyperactivity. These children usually are extremely frightened of aggression and react either with fear or withdrawal symptoms rather than with aggression. They sometimes have been rejected in the home or exposed to savage fighting between parents, with the result that a show of aggression with or by adults terrifies them. In a sense they come from distrubed homes and have assumed this more passive means of dealing with their inner anxieties. It is often felt that the causations for their problems are the same as those described for other groups but that the aggression has been "beaten or frightened" out of them, and their feelings about this situation have been turned onto themselves.

These are children who feel terribly guilty, as if they are to blame for everything. They can be worried about being destroyed or annihilated, and along with their loss of aggressive capability is their concomitant loss of an ability to compete. They therefore find a setting such as the school relatively intolerable, because it requires a certain performance and functioning level which they feel incapable of meeting.

(b) General Observations - This child by virtue of his passivity is often overlooked because he tends to be docile and manageable by the usual classroom standards; therefore, his symptoms can go undetected for longer periods of time. On the other hand this type of passivity can provoke irritation in some teachers who find themselves responding with impatience and anger.

(c) Pupil Adjustment Counselor Involvement - Depending on the particular symptom(s), the Pupil Adjustment Counselor may or may not work directly with this child. What needs to be determined diagnostically is whether direct contact with the child at the outset may be more frightening to the child than the value of the contact itself. As this child is studied and understood by other means (e.g., teacher and home involvement), the role of the Pupil Adjustment Counselor in regard to direct involvement with the child will emerge more concretely. This differentiation is made because unlike the yperactive or aggressive child, attempts to get this child to stop biting his fingernails or manipulating his genitals may throw the child into confusion and increase fear. Since these symptoms are turned onto the child himself, they also do not require the immediate control and management techniques vital to dealing with the overly-aggressive child. From a clinical point of view these children are quite masochistic, which ultimately requires more subtle approaches and treatment.

(d) Teacher Involvement - The teacher's role with this kind of child can be crucial. Attempts should be made to interest the child in "busy" activities. For example, this child can be grouped with other children manifesting similar problems; the teacher may be able to plan a separate program for these youngsters within the more general framework of the kindergarten program. The more gentle the approach, the more chance there is of allaying the child's anxieties.

(e) Home Involvement - This is advisable but qualified somewhat by the child's responsiveness to the attention he receives in the classroom. Again, home involvement is somewhat dependent on the intensity and persistence of the child's symptoms. There is a constant need to weigh the time factor in order to determine whether the symptoms are markedly reduced as the child settles into the school routine. Diagnosis of the child's behavior pattern will largely determine how much home involvement is necessary.

(f) Other Agency Involvements - Involvement ranging from a contact with a family service agency to a child guidance clinic may ultimately be indicated. This depends on both diagnosis of the severity of the problem and the parents' willingness to accept help. In the case of children whose isolation muteness is severe, strong influence should be exerted on the parents to seek remedial treatment.

(g) Summary Contents - This particular group of children raises a controversial diagnostic issue which does not arise in relation to the previously described symptom groups. The Pupil Adjustment Counselor is confined to dealing with youngsters whose behavioral problems interfere with learning. Decisions need to be made about some of the children in this group when it is clear that although a child is manifesting certain anxiety symptoms, he is able to function fairly adequately within the general range of expected performance. For example, nail-biting by itself is no measure of the child's ability to function scholastically and yet it is a clue to intense inner anxiety which may have broader implications than the surface symptom reveals. Here again, careful diagnosis needs to be made and underlines the suggestion that the Pupil Adjustment Counselor and teacher very carefully and slowly approach these children or the issue of home involvement.

PRIORITY E

1. (166) Symptoms: Whining, Crying, Fretting, Thumbsucking

(a) Causations - This group of symptoms usually characterizes the child who has been greatly infantilized at home. The common description is that the child is "acting like a baby". It is no accident that this behavior is described in this way. The child literally has not been given the opportunity to develop substantially beyond the age of two to three in terms of ability to cope with his environment. These children often are described by teachers as immature.

Among reasons for infantilizing children is the need for the mother to cling to the child by keeping the child in an infantile status. Additionally, these children may have developed this approach to the environment as a way of getting attention, because this is the only pattern of attention-giving to which parents have responded. The thumbsucking by itself usually combines both intensive anxiety and problems with wetting in the early period of life. Again, efforts to deal with the thumbsucking need to be related to the scope and intensity of the underlying anxiety.

(b) General Observations - This group is equally upsetting to the school since the infantile behavior provokes irritation and impatience. The impulse is to push the child to "stand on his own feet" and to demand from him a maturity commensurate with his age. This may or may not be effective depending upon how deeply rooted the symptom is. Intensive physical examination is mandatory for this group, especially if the child is one who frets. This child may be responding to inner physical problems without being able to pinpoint the source of his difficulty. The symptoms also can be the precursors of a physical illness or the existence of a low grade virus infection.

(c) Pupil Adjustment Counselor Involvement - The counselor may or may not become directly involved with the child. If physical causation is ruled out by examination, Pupil Adjustment Counselor involvement will depend upon how much the counselor feels he can contribute to helping the child deal more maturely with the school experience.

(d) Home Involvement - Contact is usually required, especially if the child's immaturity interferes with his ability to participate in the kindergarten program. The child also may be expressing problems of separation from his mother.

(e) Other Agency Involvement - If this is a persistent personality problem, the more fruitful contact may be with a social agency to help the parents deal with those factors which are causing them to infantilize their child. If additional help is required, a child guidance referral may be appropriate.

All of the above material does not exclude other possible resources for help in dealing with the problems of these children. It is true that their age restricts the range of activities into which they can be placed; however, if they are to remain in the public school setting, special programs in afternoon socializing and recreational activities can be sought in settlement houses. It may be possible to transfer some of the more disturbed youngsters to nursery programs where the staff is trained to handle them. In rare instances, residential in-patient care may be required along with separation from the family. This will necessitate the mobilization of adequate diagnostic resources before such planning is attempted.

2. (170) Symptoms: Stuttering

(a) Causations - Recent studies of stuttering among children attribute the cause to unresolved hostility. This hostility is directed toward one or both parents and is unconscious. A child who stutters is described by clinicians as one who "bites off his words". This biting phenomenon is attributed to the underlying hostility.

(b) Pupil Adjustment Counselor Involvement - There is real question whether the Pupil Adjustment Counselor should become involved with this child except as it may be pertinent to working with the parents toward getting the child some help. He may establish an acquaintance with the child and possibly discuss getting help with the problem. Beyond this, the Pupil Adjustment Counselor should not attempt treatment of any kind.

(c) Home Involvement - The Pupil Adjustment Counselor may initiate discussion with the parents around the problem and should encourage parents to seek professional help.

(d) Other Agency Involvement - There are several methods by which stuttering is treated: child guidance clinics, speech therapy classes, and persons doing guidance counseling deal to varying degrees with this problem. Not all such facilities attribute the same causes to stuttering as are indicated above. However, youngsters can reduce their stuttering through help from these resources.

3. (172) Symptoms: Lisping and/or Baby-Talk

(a) Causations - These two symptoms are related in instances where they are an expression of regressive behavior. However, when lisping occurs alone and is persistent in the child's speech, it may be attributed to the growth pattern of the teeth and difficulty in effective use of the tongue to form sounds. Many children who have had little orientation to the verbal word in their early years may slur or lisp certain words in their speech. Baby-talk is more explicitly seen in a child who at any age is asking to be treated like an infant. Parents who have over-induced and infantilized their child contribute to this behavior. Diagnostically, differentiation needs to be made as to whether the lisping in the same child or by itself is also a similar manifestation of regression.

(b) Pupil Adjustment Counselor Involvement - With the regressive child, the Pupil Adjustment Counselor may utilize a relationship to help him recognize the inappropriateness of the symptom. This, however, cannot be done by exhorting or confronting the child directly. Rather, a more indirect process is called for in which the counselor brings to the child's attention the fact that he is using baby-talk in his presence and asks the child why he speaks in this manner.

(c) Home Involvement - In the case of baby-talk and lisping, contact with parents should be made in order to help parents recognize the problem and seek help.

(d) Other Agency Involvement - The severity and persistence of the baby-talk problem will somewhat determine the resource to be utilized. If the problem is persistent and deeply imbedded in the parent-child interaction, a child guidance facility is advisable. It is also possible that the child's problem may be remedied by dealing primarily with the parents in a family agency setting. Less severe regressions may be remedied by utilizing a group work setting where the child's socialization pattern can be encouraged.

Depending on its etiology, lisping may lend itself to speech remediation especially if it resembles stuttering. Lisping problems arising from mouth malformation can be dealt with by teaching the child how to use his tongue and jaw to overcome his difficulty.

B. GRADES ONE THROUGH THREE

PRIORITY A

1. Symptoms:

Persistence of any of the previously described symptoms. Generally, if the symptoms described for the kindergarten child persist through the first to third grade, it is clear that the child is struggling with problems that are not transitory.

(a) Pupil Adjustment Counselor Involvement - Involvement with the child is again dependent upon the nature of the symptom and the previously described value(s) of contact with the child.

While this child will need some form of treatment, the teacher can play a crucial role in any such on-going program. For example, the less aggressive of these symptoms will more readily permit the child to remain in the classroom. However, teachers should recognize that children who retain this symptomatology through the first and third grades are usually quite disturbed and will not respond to the usual methods of handling.

(b) Home Involvement - Contact with the home is required because the long-term nature of the problem indicates a pathology that is rooted in the child and calls for more intensive work with parents.

(c) Other Agency Involvement - Referral of these cases is generally indicated but is somewhat dependent upon the skills and caseload of the Pupil Adjustment Counselor. In some instances, the child can be referred to a child guidance clinic; and, if the Pupil Adjustment Counselor has a continued and meaningful relationship with the parents, he may want to continue working with the family. These cases can be handled also in combination with psychiatric help for the child and a family agency's help for the parents. In any event, if the child has not responded in kindergarten to the kinds of remediation described previously, other clinical services are necessary.

2. (206) Symptom: Fire-Setting

(a) Causations - More and more evidence of severe pathology is being uncovered in studies of fire-setters. Persistent fire-setters may be schizophrenic children whose pathology derives from the early parent-child interaction dating back to the first and second years of the child's development. The child who sets one fire may not be in this category, but he should be watched because this may be the outbreak of continuous fire-setting or other kinds of severe and violent behavior.

Increasingly, connections have been made between the personalities of fire-setters and people who are violent and assaultive. While the findings are not conclusive, it is dangerous to minimize the problem or attempt to handle it with the usual admonitions. The relationship of the fire-setter personality to early family circumstances is borne out by continued work with the parents of such children. Very often it is found that the child is hated or that he is being encouraged to set fires by a severely disturbed or actually psychotic parent. Children who are found setting fires in the school basement or surrounding area, or children who are known fire-setters even though the incident occurs outside of the school area should be referred for clinical help. Another difficulty in relation to establishing causation is the fact that when parents are confronted with the information that their child set a fire, they often deny knowing anything about it. It is not clear whether they know about it and deny it, or whether they actually have no knowledge or have blocked it out.

(b) General Observations - The need for immediate clinical attention for the child who manifests this symptom should be stressed. Such attention may include the necessity of immediate court action in order to bring the child into a controlled setting. This is emphasized here because it is often true that people working with children are reluctant to use the authoritative services of the community. Experience, however, has shown that children who are involved in this kind of activity are sometimes seeking, and always are in need of, controls. The usual outside environment or the home cannot provide such controls. To bring such a child to the attention of the court and to insist on commitment is most often the best way of handling this situation.

(c) Pupil Adjustment Counselor Involvement - This is not a case to be handled outside of a clinical environment. The Pupil Adjustment Counselor should contact the child directly, with the intent of moving as quickly as possible to have the child referred for comprehensive study and evaluation. Any discussion of fire-setting with the child should be limited to the idea that the Pupil Adjustment Counselor wishes the child to get help. Exhortation, threats, and dire predictions should not be used.

(d) Home Involvement - Obviously, direct involvement of the parents will be mandatory. Because of the seriousness of the symptom, again court involvement may be immediately advisable. Such court involvement is required because the parents often attempt to minimize or deny the seriousness of the problem and need the reality of authoritative confrontation in order to recognize that they cannot or should not avoid beginning to deal with the problem. It should be recognized that a child who sets fires at the age of six is beyond the stage of either playing with matches or learning about what fire is. Characteristiclly, the Pupil Adjustment Counselor may find, upon exploration, that there is a tremendous amount of rage in both the parents and children in this group. While parents need to be confronted with the seriousness of the situation, a punitive approach will frighten them into withdrawing or avoiding contact with any source of help. Contact with parents therefore requires a combination of pointing out the seriousness of the problem and the need and availability of help.

If other agency involvement is required for diagnostic and treatment purposes, an organization like the Youth Service Board's Reception Center or Detention Center and a child guidance setting may be appropriate. Help for this kind of child also can be obtained through court clinics in districts where they exist. This is the group which judges will often send to the Metropolitan State Hospital for a period of observation. There is reality in the recognition that this type of symptom is dangerous to both the individual and the community.

3. (224) Symptoms: Open obscenity in language and behavior

4. (226) Symptoms: Lewd mannerisms, unprovoked sexual behavior toward same or opposite sex, clutching genitals, possession of obscene pictures

(a) Causations - (both) - Sexual behavior among children of this age can represent response to over-stimulation at home, coupled with an expression of deep anxiety. These children may come from homes where the parents are creating an overly-stimulating atmosphere and in some instances where there has been uncontrolled sex play among siblings; in the extreme, the home may be characterized by openly promiscuous sexual behavior by parents.

In its mildest form, the use of obscene language may simply be an imitation of peer behavior in the neighborhood. However, anything beyond this usually has pathological roots and requires more intensive attention.

(b) Pupil Adjustment Counselor Involvement - The Pupil Adjustment Counselor should become directly involved with the child, acting as a role model in order to help him develop behavior controls. The adjustment counselor also should help in the differential diagnosis. For example, a child who overtly masturbates at school may be far more disturbed than the child who is lewd or uses obscene language. This differential diagnosis will affect the Pupil Adjustment Counselor's approach to the child.

(c) Home Involvement - This is required. It is an unusual case when this problem is not embedded in the home situation. In the exceptional case, the obscene language is purely an imitation of the peer group.

(d) Other Agency Involvement - This is often necessary if the symptoms persist and do not respond to the teacher's and the Pupil Adjustment Counselor's controls. If possible, this kind of child should not be exposed to authoritative control; a clinical setting should be sought. The imposition of authoritative controls may thrust the child into a group setting in which he continues or increases his sexual activity. Unfortunately, the nature of this activity produces anxiety among people confronted with it. As a result, children often are severely punished because of this.

Clinics can be helpful in making the differential diagnosis because it is also important to know the full nature of such behavior. If, for example, it is learned that this child also behaves sadistically among his peers, the sexual behavior may have serious consequences if unattended. In this group we sometimes discover the child who assaults a neighboring girl with a knife and forces her into some form of sexual behavior with him.

PRIORITY B

1. (230) Symptoms: Truancy (more than occasional)
2. (232) Symptoms: Prolonged or continued absence from home (including the runaway)

(a) Causation - The causations of truancy, prolonged absence from home, and running away are multiple. They may derive from the child's failure to achieve in school and his need to avoid the continued tension of competing unsuccessfully in the classroom. They may appear to be responses to difficulty with a specific teacher and to the child's need to avoid a traumatic situation.

In some instances the child may be a truant because his parents are unaware of the premium which the community places on school attendance.

In other instances, the child may be a truant because he is afraid of something that is going on at home and may feel that he should stay at home in order to be sure that nothing will happen. (In these cases violent physical abuse customarily occurs between the child's parents, and the child is afraid to leave home for fear that something will happen to his mother.) The truant child who also runs away from home or is absent for long periods of time may still be reacting to a very bad home situation by avoiding these stressful situations. These symptoms may represent the repetition of a pattern of failure in life situations by running away from stress.

(b) General Observations - Although the truant or the child who runs away from a bad home situation must be controlled, it is necessary to recognize the specific issues which underlie the reasons for this behavior. When a child is truant, the school has no choice in its ultimate action; the child must be dealt with through official channels. Therefore, a comprehensive diagnosis should be completed as quickly as possible. Because studies have shown that truancy is a forerunner of delinquency, and because of the delinquents who appear before the courts or the Youth Service Board have a history of avoiding school, truancy should not be routinely handled until court action is necessary. Court action may be inevitable, but if possible the truancy should be dealt with earlier.

(c) Pupil Adjustment Counselor Involvement - Contact with the child can be extremely helpful when the Pupil Adjustment Counselor is seen in the role of an authoritative but interested adult. The Pupil Adjustment Counselor is in a position to elicit the nature of the problem from the child during an extended period of time, unless the child becomes a truant or runaway in response to purely subconscious stimuli (e.g., the desertion or death of a loved one). In these instances, the child will not be able to articulate the causes. It is imperative to understand that children in this age group are extremely protective of parents who are acting out; they will not necessarily divulge the source of their anxiety, although they are quite consciously aware of it.

(d) Home Involvement - Mandatory. - The causes of truancy, running away, and/or prolonged absence from home are based either in the home situation or the school situation. These need to be detected quickly so that appropriate remedial steps can be taken.

(e) Other Agency Involvement - Authoritative agencies often are forced into involvement or may be brought in by parents or other concerned adults. The truant or runaway child either gets into trouble with the law or is sought by enforcement persons. Planning will often be coincident with the efforts of such authoritative agencies unless the truancy is attended before the school law has been broken and while parents are easily amenable to remedial action. (Such remedial steps may include referral to a social agency or child psychiatric facility.) The Pupil Adjustment Counselor in conjunction with the attendance officer may wish to use the authoritative role of the court in order to provide external controls to the child and his family. This is therapeutic if it is coupled with a treatment program. Attempts to provide remediation without legal action should not be prolonged indefinitely since this will be indicative of parents' and child's inability to impose internal controls.

3. (234) Symptoms: Stealing (environmentally induced)

(a) Causations - These are similar to those described under "Lying (environmentally induced)". An added ingredient in this type of stealing is peer group pressure. A child who needs to be approved and accepted by the group will often "go along" with group stealing in order to retain his group membership. Any sense of guilt is minimal because the symptom is "acceptable" behavior by the peer group.

(b) Pupil Adjustment Counselor Involvement - See "Lying (environmentally induced)".

(c) Home Involvement - Mandatory. - The parents and the child perceive the problem in the same way. In this instance, the Pupil Adjustment Counselor should point out the problem as it affects the child in the school setting -- with teacher and peers. If stealing persists, the Pupil Adjustment Counselor should discuss referral to a social agency and/or a psychiatric clinic. Parents may deny the problem and insist that the child is innocent. Such denial may be difficult to counter; if the stealing persists, however, parents need to be continually confronted in a positive, understanding way until they can accept that the child has a problem and they are willing to get help for the child. Parents may provide a history of other kinds of stealing and show a helplessness in dealing with it.

As is true for lying, the difference between environmental stealing and stealing as a pathological entity is difficult to discern. However, in order to avoid treating every act of stealing as pathological or as a result of difficulties in the parent-child relationship, it is necessary to enlist the parents' and child's help in getting at the causes. An important clue is the child's responsiveness to the Pupil Adjustment

Counselor's direct efforts to help. In addition, early cooperation from the parents is a clue to the depth of the problem for the child.

Unfortunately, when a situation arises in which the child is forced to choose between the demands of the broader, organized society and those of his peer group, the stealing will not stop but will only shift its locale; that is, if it becomes unwise to steal at school, it may be all right to steal in other settings. This is true for all problems which have status or meaning in the peer group relationship. In some respects the only ameliorative process is that which deals with this particular problem on a total group basis.

(d) Other Agency Involvement - A group experience for such a child has great merit because it offers potential for involving and identifying the child with a peer group which has a different set of values. Here again, environmentally induced stealing may stop if the child can be helped to identify with the community center group.

It is possible to arrange with a local community center a program which can include a large segment of the child's regular peer group. This recommendation is in keeping with the idea that stealing as described above is hard for the child to stop if it means isolation from his group and sometimes retaliation, taunting, and torment from his peers.

4. (236) Symptom: Stealing (pathologically derived)

(a) Causations - When stealing is not caused solely by environmental pressures, its causes are confusing and multiple, What must be kept in mind is the nature of the interaction between parents and child as a primary source of difficulty. Disturbances in this interaction may cause a child to steal in order to get attention, because he feels deprived, because his parent(s) provoke and stimulate him to steal, either to obtain vicarious gratification from the child's act, or to provoke the child into acting out a bad part of themselves. A child may steal as a means of indicating his lack of identity or because he feels unloved and needs to steal "love". He may steal in order to retaliate for what he perceives to be wrongs perpetrated upon him. If his parents deny him certain material things, he may steal to obtain them. In this incomplete conglomeration of possible causes, the crucial need is for differential diagnosis so that appropriate treatment can be planned.

(b) Pupil Adjustment Counselor Involvement - Over a period of time the Pupil Adjustment Counselor can become an extremely meaningful figure to the child by serving as a role model and by establishing a firm, consistent relationship which provides the child with the emotional gratification which he lacks. The role model function in this type of situation is not sufficient by itself. The child will need help in utilizing this relationship if the need for emotional gratification arises from a relationship in which the adult is giving without being punitive or judgmental, and simultaneously does not condone the child's anti-social behavior.

(c) Home Involvement - Mandatory. - It is necessary to obtain appropriate information both for diagnostic purposes and for developing a relationship with the parents which will lead to a treatment program.

(d) Other Agency Involvements - The treatment program for a child whose stealing is pathological may involve two or more services simultaneously. Stealing which cannot be arrested by the usual means may well require intervention by authoritative resources. Referral to a community center, a child guidance clinic or a social agency has to depend to a large extent on how much the problem has been internalized by the child. When dealing with youth at the first to third grade level, it is within reason to assume that the child may not have centralized the problems to the extent that he requires psychiatric treatment. Here again, differential diagnosis is necessary in order to determine whether the child requires referral along with the parents, or whether the problem can be dealt with by working with the parents alone. This kind of social agency treatment, combined with referral of the child to a community center group experience, may be sufficient.

5. (238) Symptoms: Lying, Cheating (environmentally induced)

(a) Causations - A child residing in a neighborhood where this pattern of reacting to situations (and especially toward authority figures is common) is well apt to feel that such behavior is the "normal" way of dealing with situations in school. While it is difficult to differentiate this group of youth from those who lie and cheat for pathological reasons, it is important to keep in mind that the child's use of this behavior may simply be a learned pattern of response.

(b) Pupil Adjustment Counselor Involvement - Work with this child can be extremely meaningful. He may find it possible to unlearn this kind of behavior if he can identify with the Pupil Adjustment Counselor. Specifically, the Pupil Adjustment Counselor should provide a role model with which the child can identify.

(c) Home Involvement - The Pupil Adjustment Counselor must alert the parents to the child's problems. If the diagnostic impression is that the child is simply responding to something which he learned from his environment, work with the parents may be minimal without the necessity of the Pupil Adjustment Counselor's dealing with what he perceives to be parental problems. If they are capable of understanding the fact that the school

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does not accept this kind of behavior, and if they can permit the Pupil Adjustment Counselor and other school personnel to help the child work out his difficulties, this, from the school's point of view, constitutes a sufficient treatment program.

(d) Other Agency Involvement - If the Pupil Adjustment Counselor feels that this kind of child also can benefit from a group work-experience, the child can be referred to a settlement house or similar group program.

6. (240) Symptoms: Lying, cheating (pathologically derived)

(a) Causations - Unlike Priority B, the causations for these symptoms are more deeply rooted in the parent-child relationship. The symptoms are more persistent in nature and the history usually shows that the problem began very early in the child's life. The child needs to use this kind of behavior to get love and attention, to avoid punishment, or to demand certain things from his disturbed parents.

(b) Pupil Adjustment Counselor Involvement - While the teacher's role remains substantially the same, the Pupil Adjustment Counselor should become much more involved in the home situation. Referral to other agencies may include a family service or child guidance setting.

Potential methods for differentiating between environmental and pathological lying and cheating lie both in the duration and persistence of the problem and in the parents' attitudes when the problem is discussed. The environmentally induced lying and cheating elicit a somewhat guilty response from parents because it generally does not characterize their approach to the community in general. Where there is a pathological interaction, parents tend to show more hostility and denial, and attempt to project responsibility for the problem on to a "harsh" or "unfair" teacher. This occurs primarily because they are unable to recognize or cope with the child's problem, contributing as they do to the problem. In the extreme case, parents will completely reject the child - "throwing him to the wolves" as a way of getting rid of the emotional entanglements.

7. (242) Symptoms: Depression

(a) Causations - The phenomenon of depression among children is a complicated one and does not manifest itself in the same way as it is generally perceived in adults. It is, therefore, much less discernible and while treated here as a separate symptom, may be a phenomenon in combination with most of the other behavioral symptoms described; it may be a basic symptom which is causing some of the other behavioral problems.

Studies have pointed to certain kinds of behavior as an attempt to "flee" from the feelings of depression. Other studies have indicated that children suffer depression if they feel unloved or unwanted. They may or may not reveal this depression directly. Children who cry and appear sad and who become extremely upset when someone else is hurt or dies may be reflecting an underlying depression. Extremely important is the question of whether such a child has recently suffered the loss of a key figure in his life. Children who are emotionally healthier may be able to express their grief at such a loss more directly even at this earlier age.

(b) Pupil Adjustment Counselor Involvement - The Pupil Adjustment Counselor should not attempt to treat this child for depression. Children cannot respond to direct questions regarding feelings of depression through late adolescence; even at this late age they often do not know what the questions mean. However, in dealing with all children, this symptom must be watched for and, if the counselor perceives open depression in the child, his interest in the child's general well-being can be extremely important and meaningful.

(c) Home Involvement - The extent and depth of home involvement will depend on whether the depression is overt, whether it concerns a recent loss, and whether the parents are able to verbalize their own feelings of depression. It should be remembered that studies have shown that many of the parents who will be encountered are themselves suffering from underlying feelings of depression.

(d) Other Agency Involvement - This dependent on an appraisal of how depression manifests itself and how it should be treated. The overtly depressed child who has suffered a loss may be helped by becoming involved with group work-agencies. If the depression is perceived as the result of the child's feeling rejected or unwanted, clinical services should be sought.

8. (246) Symptoms: Defiance of Teacher's Authority

(a) Causations - This child often manifests unruly behavior in the classroom and in the school yard; he is fresh toward teachers and sometimes resorts to uncontrolled swearing when angry. Most often such a child's behavior is related to difficulties in the parent-child home interaction. This child may be in a continuously hostile interaction with one or both parents and may be acting out a specific defiance of their authority. Often, simultaneously, he handles his defiance in the way his parents express theirs, (that is, his parents utilize the same general way in dealing with authority). The Pupil Adjustment Counselor should be alert to the possibility of brain damage or other physical difficulties to which the child's behavior may be attributed. Ruling out these possibilities, he should look for a father who may have a pattern of uncontrollable swearing when angered, and parents who generally use aggressive and hostile means to cope with their environment.

(b) Pupil Adjustment Counselor Involvement - As a controlling, limit-setting figure, the Pupil Adjustment Counselor should help the child primarily to recognize that his needs and demands can be met in less disruptive ways. Even though the child's means of expressing his problem stems from his home situation, he may be able through identification with, and the persistent interest of the Pupil Adjustment Counselor, to control his behavior in the school setting.

(c) Home Involvement - Necessary. - Parents often may present a picture of noting this behavior in the child and maintaining that they are unable to cope with it. While their defenses should not be openly attacked, exploration should focus on discovering what in the parent-child interactions causes the child to use these approaches to the outer community. If the causes are related to parental use of extremely repressive measures, parents should be helped to relax their iron-like control over the child.

(d) Other Agency Involvement - Such a child frequently can be helped through contact with a group activity program, even though his specific difficulty may not be with his peer group so much as with adults. Added to his adjustment difficulties is the fact that his behavior may be encouraged by his peer group, because he is "acting out" behavior in which they might wish to indulge but are afraid to emulate or initiate. If the problem is deeply rooted in the parent-child interaction, it may be necessary to arrange a referral to a social agency or child guidance clinic.

Also, see: Kindergarten - (4) under Priority C - "Difficulty with Basic Classroom Discipline".

9. (250) Symptoms: Exhibitionism

(a) Causations - This symptom by itself is closely related to what is considered "excessive cuteness" in the younger child. It lacks the sadistic components described in the next category under bullying, and it usually signifies the child's attempt to gain and hold attention. Problems in this area stem mostly from difficulties which the child had during the third through fourth or fifth years. Clinically, the child going through a normal maturation period discovers his "body" approximately at the age of three. He has no shame about the various parts of his body unless he has been severely treated during bowel training. This lack of shame prompts him to be "proud" of his body, to show it off, to seek admiration from others in regard to newly discovered prowess. All too often this normal exhibitionistic quality is seen as a dangerous manifestation of sexual aggression in the child. The child is sometimes considered "fresh" or "dirty"; in other instances the child may be overly encouraged in the exhibitionism by parents who are acting out their own subconscious needs. If the child is not able to move through this period (which commonly is known as the phallic urethral period) in reasonably normal fashion, one of the results may be a need to regress continually to this earlier period in order to seek the approval he did not get, or to seek again the over-gratification he received. Conversely, if this period is associated with "sinfulness" or "badness", the child may be acting in an exhibitionistic way in order to be punished for his bad or hostile thoughts.

(b) Pupil Adjustment Counselor Involvement - The Pupil Adjustment Counselor can help such a child at this age by not taking a punitive or disciplinary attitude toward the child's "antics" but through sympathetic contact he may help the child see that such behavior is not necessary or useful in his relationships with adults and peers.

(c) Home Involvement - Mandatory. - The exhibitionistic child at this age is "less cute" and his behavior becomes a source of irritation to those around him. If the parents tend to encourage this behavior because they need to feel "important" through the child's behavior (i.e. if they wish to be seen as having an "exceptionally talented" child), they will be difficult to reach. If they are threatened by the child's behavior, they may be punishing the child excessively.

(d) Other Agency Involvement - This will depend to a considerable extent on the derivation of the problem. If there are not deep pathological roots associated with the problem and if parents are reasonably cooperative, additional help may be sought for the child in a group setting where exhibitionism becomes channeled into appropriate activities from which the child obtains appropriate gratification. If the exhibitionism is more related to "sinful" or "bad" thoughts or behavior, the parents may need referral to a social agency and/or the child may need referral to a child guidance clinic.

PRIORITY C

1. (254) Symptoms: Bullying

(a) Causations - In addition to the usual definition of a "bully", we see this behavior in combination with an overly-boastful, domineering, and aggressive attempt to assume leadership and control. This child usually is reflecting the way he is treated at home, either directly by his parents or as a scapegoat by older siblings (permitted by his parents). He also may be identifying with a domineering parent in order to stay on the "good side" of that parent. His wish to lead may be forced on him by over-demanding parents, and he may react by taking leadership in an over-aggressive fashion. Basically, he may be quite frightened of assuming this role and may be constantly fearful that his role will be challenged. This child may sometimes be sadistic in his behavior toward other children, showing pleasure in tormenting and hurting smaller children. He often is the victim who has become the tormentor in other situations. His exhibitionism may cover deep feelings of inferiority, and may be part of his method of controlling less aggressive and less "showy" children.

(b) Pupil Adjustment Counselor Involvement - This child desperately needs the attention of the Pupil Adjustment Counselor. A relationship with an understanding adult will provide such a child with the security aimed at reducing the child's need to punish others. However, caution needs to be observed if the child does not respond readily and positively to this relationship. The sadistic behavior may have a long history and may again be rooted in the parent/child interaction.

(c) Home Involvement - This is mandatory, especially since it is necessary to determine possible causes of the child's behavior. If the child's bullying pattern is directly related to the handling of frustration, this pattern should emerge around similar stress situations. It is necessary to define what the child's relations are to siblings, and what parental patterns the child may be emulating.

(d) Other Agency Involvement - This will depend on the manageability of the problem. A corrective group work-experience can be helpful. However, if the bullying patterns are deeply persistent and involve highly sadistic components, clinical treatment may be necessary.

2. (256) Symptoms: Slyness; Underhanded and Generally Untrustworthy Behavior

(a) Causations - This child is commonly described as "shifty". "underhanded", and "generally untrustworthy". The underlying problem with which this child is struggling may be associated with parent-child interaction. This is a child whose environment has been fraught with uncertainty and great deprivation. He has had to learn an adaptive pattern of behavior in order to survive. He cannot take anything openly; his whole life has been one of having to deal surreptitiously with people. Unfortunately, this method of coping with the environment develops into a gratifying experience in which the child finds himself outwitting and out-maneuvering less devious people, and the pleasure derived from this causes him to use this manner of dealing with people even when it is not necessary.

(b) Pupil Adjustment Counselor Involvement - This child needs a relationship with an adult, so that his behavior can be altered through direct interaction with someone like the Pupil Adjustment Counselor - who accepts him and simultaneously confronts him with the deviousness of his behavior.

(c) Home Involvement - The Pupil Adjustment Counselor will need to work with the parents, recognizing that they created the original atmosphere in which the symptoms developed. In this point of contact, parents may well describe the child as a problem to themselves and will ally themselves with the Pupil Adjustment Counselor against the child.

(d) Other Agency Involvement - This will be necessary depending upon the extent to which this is the child's behavior pattern. Again, a corrective group experience may be extremely important in helping such a child change his behavior patterns. Whether a family agency or a clinical setting is to be involved should be determined by the extent and depth of the problem.

3. (260) Symptoms: Defiance, Unruliness, Disrespectful Attitude, Uncontrolled Swearing

See (8) under Priority B; Grades One through Three

See (4) under Priority C; Kindergarten

PRIORITY D

1. (268) Symptoms: Learning Problems -- When it is diagnostically clear that behavior bears directly on slowness of learning

(a) Causations - Learning problems have many possible causes. Undue anxiety because of a difficult home situation may prevent a child from studying or maintaining attention. If the home is disrupted by family discord, the child may not be able to complete his study assignments. In situations where children are neglected, it has been found that the basic physical necessities (heat, light, food, etc.) are absent or intermittent in supply. This can cause a child to fall behind.

Children who are having a severe difficulty with one or both parents may react to a teacher who handles them in similar fashion and may develop blocks to learning in that particular class or subject. Psychoanalytic study advances the possibilities that a failure to achieve in certain subjects may have origins in early life experiences; a child having difficulty in studying history, for example, may be frightened about "exploring the past" in terms of earlier difficulties in his home life. Fears about competing, about being "too bright", about being made to feel "stupid" are all possible factors that may explain learning problems.

discomforted by any show of spontaneous friendliness or warmth. The symptom can derive also from experiences during the bowel training period in which the child has been made to feel shame and embarrassment. Thus, any attention brought to him (such as the simple act of being called on in class) evokes the fear that he will be shamed and embarrassed again in public. This is also a child who has been repeatedly ridiculed and devalued and who fears the same experience in the classroom. In other instances, this behavior may represent an attention-getting mechanism, a device developed by the child to cope with situations calling for self-responsibility.

(b) Pupil Adjustment Counselor Involvement - A relationship with this kind of child can be very crucial and helpful. While there can be no direct confrontation of the child's feelings of shyness and embarrassment, the counselor's getting to know the child in less threatening subject areas can convey a sense of security and alliance so that the child is less concerned with becoming overwhelmed or embarrassed in the classroom setting.

(c) Teacher Involvement - The teacher may help this child considerably through private conversation by making the child aware that the teacher is there to protect the child from being embarrassed or humiliated. Calling on the child in class can be handled in a fashion similar to that prescribed for the stuttering child.

(d) Home Involvement - The home situation should be explored, but the symptomatology will not be as apparent as a problem to the parents. Therefore the approaches should be somewhat more subtle. Parents will often identify themselves with the child, claiming they are beset with the same problems. In working with the child, it may be necessary to focus on getting the parents' permission to maintain a helping relationship. In this kind of situation parents often will not see the need for treatment.

(e) Other Agency Involvement - If the problem is sufficiently severe (i.e. approaching phobic proportions for the child), child guidance or family agency assistance is necessary. Less severe problems of this nature respond well if the child can be involved in a supervised group.

PRIORITY D

3. (276) Symptoms: Overcontrol and Self-Restraint, Over-Politeness, Excessive Fear of Authority

(a) Causations - This child usually sees any form of aggression or anger as dangerous. This is usually a child who has grown up in an environment where the slightest amount of self-assertion, aggression or hostility has been crushed by overt counter-aggression on the part of parents; or by quiet, rigid control imposed by parents; or parents who utilize real or imagined illnesses to keep the child from expressing aggression. The child is fearful in these instances that such aggression will make his parents more ill or may even kill them. The difficulty for everyone concerned (and especially for the child) is the fact that the child's hostility simmers underneath. In this respect, the child often turns the hostility onto himself and develops somatic symptoms. Such a child can give a helping adult an uncomfortable feeling unless the adult recognizes that the over-politeness is not necessarily a "virtue" and that the child is basically restricted and angry.

(b) Pupil Adjustment Counselor Involvement - Diagnosis is crucial. For such a child, if the price of open hostility and/or aggression is to hurt or "kill" one's parents, it will be extremely difficult to elicit these kinds of responses because the child will suffer any outside pressure in order not to retaliate against his parents. If the Pupil Adjustment Counselor feels this to be the case, his work with the child should be minimal or non-existent. If, however, the situation is not as dangerous for the child and is more associated with parental attitudes toward aggression; the Pupil Adjustment Counselor, in fairly regular contact with the child and accompanied by contact with parents, can help the child express his aggression or hostility more freely.

(c) Home Involvement - The nature of the problem itself makes it extremely difficult at times to approach the parent. It puts the Pupil Adjustment Counselor somewhat in the position of complaining about a child who is behaving "too well". Unfortunately, unless the child is helped to release some of the natural, underlying hostility and/ or aggression, he is beset with problems which may affect his potential or cause him to be excessively concerned about doing well in school to the point of suffering anxieties as a result of what he considers "failure". The extent and nature of the problem, from a diagnostic point of view, should be determined.

(d) Other Agency Involvement - Only when parents fully recognize that their child has problems can one utilize the services of child psychiatry. Parents in this type of case should accept the idea that the child's suppression or repression of hostility is an unhealthy phenomenon; it is not socially acceptable or an indication of a "good" child. Community center activities can be an important first step in helping such a child "break through", at least among his peers. Parents will sometimes accept referral to a social agency to discuss ways of helping the child express hostility more freely.

4. (278) Symptoms: Accident Proneness -- Continuous Physical Injury

(a) Causations - There is increasing evidence that accident proneness is related to impulsive behavior. This symptom appears frequently in groups of children where parental neglect and juvenile delinquency are often concommitant problems. It is not clear whether the child is acting out an unconscious communication between himself and his parent(s) which reflects his parents' constant fearfulness or wish that the child will be injured. These are often children who appear to disregard their personal safety to the extent that they get into situations where personal injury comes easily.

(b) Pupil Adjustment Counselor Involvement - Accident proneness, having both psychological and physiological components, should not be dealt with directly by the Pupil Adjustment Counselor. The counselor's role is to arrange for diagnosis and possible treatment through other facilities.

(c) Home Involvement - Parents should be alerted to the idea that accident proneness is not something the child needs to endure and that there may be a psychological basis for his continued accidents. The parents should be encouraged to seek help for their child.

C. GRADES FOUR THROUGH SIX

PRIORITY A

1. Symptoms: Persistence of any previously described symptoms

(See category - same title under (1) Grades One through Three)

2. (304) Symptoms: Direct assault upon teachers, with and without weapons

(a) Causations - A child who is assaultive toward a teacher usually has reached a point where the controls on his temper and physical outburst are breaking through the bounds of normal restraint. Such a child may be acting out intense frustration with his home conditions which may have reached rageful proportions; with the slightest provocation he may lash out at adults in authority. Such a child sees authoritative adults as hostile and dangerous to him and will lash out at any reasonable situation. The basic problem is related to the parent/child interaction in which the child is having excessive difficulties with one or both parents. He may or may not be acting out his rages at home. In either event, his aggressive impulses are out of control and require immediate attention in the form of other controls exerted on his behavior.

(b) Pupil Adjustment Counselor Involvement - Direct involvement with the child is mandatory. It may be necessary to control such a child physically in the immediate school setting. The immediate task of the Pupil Adjustment Counselor is to help the child recognize the inappropriateness of his behavior and to serve as a control figure and role model for the child. The Pupil Adjustment Counselor needs to assure the child that he will help him control his behavior (which is basically the child's wish).

(c) Home Involvement - This is immediate and crucial. The Pupil Adjustment Counselor should determine with the parents, diagnostically, the underlying causes of the child's behavior and assist them and the child to take the steps necessary to alleviate the difficulties. A child who continues this behavior needs the services of an authoritative agency.

(d) Other Agency Involvement - As immediately as possible, the child and the parents should be referred to a child guidance clinic or social agency. This child may be helped by referral to a group work setting, but this treatment alone may not be sufficient to deal with the child's underlying difficulties.

3. (316) Symptoms: Drinking of Alcoholic Beverages

(a) Causations - Among the latency population, drinking and excessive drinking seem to be increasing. The pattern may be a mixture of simple learned responses to a drinking situation at home by a child who is relatively uncontrolled and is permitted to indulge in impulsive behavior. A child who is under excessive stress in his relationship at home may be using drinking as the usual "escape". It is not necessary here to delve into the etiology of drinking per se - the causes are manifold. What is indicated is the absolute necessity for immediate action.

(b) Pupil Adjustment Counselor and Home Involvement - are inextricably tied together. The Pupil Adjustment Counselor may discuss the drinking issue with the child, but there is an urgent need to alert the parents so that they and the child can receive appropriate help with the problem. Unfortunately, the parents of such children may deny the child's problem, or one or both parents may themselves have a severe problem with drinking. The bulk of the Pupil Adjustment Counselor's work will revolve around alerting the parents to the problem and seeing that they obtain help for the child.

(c) Other Agency Involvement - Multiple services are offered for the treatment of drinking problems. The Pupil Adjustment Counselor should contact the Massachusetts Division of Alcoholism or any one of its related clinic facilities.

4. (322) Symptoms: Continuous Fist-Fighting

(a) Causations - Some of the primary causes for this problem are included under "bullying", "defiance, unruliness", "direct assault upon teachers", "hyperactivity", and "violent behavior changes". Specifically, the child who is constantly fist-fighting may be acting out a problem with siblings in the home by transferring his aggression to his peers in the school setting. There is also a possibility in the later elementary grades that the child is reacting to stimulation from the father in the home to express his masculinity through this kind of behavior. A child, whose father manifests this type of behavior in dealing with his adult peers, may be repeating a learned pattern. In the child and adult it is rarely, if ever, expressed against persons in authority. In some instances, the child may be protecting himself from children who assault him because he is "queer" or "different".

(b) Pupil Adjustment Counselor Involvement - The Pupil Adjustment Counselor can act as a model for the child, helping him to recognize the inappropriateness of his behavior. The same diagnostic process for the categories described in causations is applicable here. Differential diagnosis will determine, to a considerable extent, the role which the Pupil Adjustment Counselor will adopt with the child. If the child needs to be defended from the group, both the child and the group will need to be helped with the problem.

(c) Home Involvement - This is mandatory for diagnostic purposes. The Pupil Adjustment Counselor may be active in alerting parents to the nature of the situation and in determining if there is great conflict among siblings to which the child does or does not react.

(d) Other Agency Involvement - This symptom by itself may not need the services of another agency for the child. He can be introduced into a group work-setting. The parents may need the help of a social agency, especially if the child is acting out mandates from the parents. The father may need help if he stimulates the child to prove his masculinity in this fashion.

PRIORITY C

1. (358) Symptom: Stubborn behavior - more deeply rooted than earlier defiant behavior, coupled with surliness and uncommunicativeness

(a) Causations - This symptom is often a forerunner to running away or truancy (see "prolonged or continued absence from home"). This child is usually expressing the results of a head-on collision with his parents and an extremely poor communication around basic discipline and control issues. This is often a child who is not "understood", or who needs to defy parental authority for subconscious reasons. There may be specific issues about which the child is consciously stubborn or defiant, but these should not be mistaken for the real issues. Some of the conscious pressures are that the child is being punished too severely, accused of misbehavior, or manifesting pseudo independence. Such stubborn behavior can relate to problems of feeding or bowel training.

(b) Pupil Adjustment Counselor Involvement - A friendly role model which respects the child's seemingly unalterable position and simultaneously works to alter it by helping the child make choices (at least in the school setting) is required.

(c) Home Involvement - Mandatory. - Stubborn behavior, coming as it does prior to truancy and running away, is at a preventive stage. Involving the parents in casework experience at a social agency or the parents and child in a child guidance experience may prevent the occurrence of more serious difficulty.

(d) Other Agency Involvement - Child guidance clinic, social agency, and group work-setting for child are possible alternatives.

D. GRADES SEVEN THROUGH NINE

PRIORITY A

1. Symptoms: Persistence of any previously described symptoms
(See same category Grades 4 through 6)

PRIORITY C

1. (462) Symptoms: Excessive adolescent rebelliousness: attempt at challenging discipline or control, stubborn, defiant freshness

(a) Causations - Adolescent rebellion which can manifest many of the forms of behavior, described under some of the other categories, will manifest itself also in stubborn, defiant behavior, freshness, and daring authorities to exercise discipline and control. Adolescent rebellion can account for some forms of truancy, if there is no previous history of truancy. Rebellion in adolescents should be understood as an intrinsically normal phenomenon - all adolescents go through this period. It is therefore crucial that caretaking people learn to differentiate between (1) normal behavior which is upsetting, but important to the adolescent, and (2) rebellion which is excessive and destructive, perhaps to oneself and others.

(b) Pupil Adjustment Counselor Involvement - The Pupil Adjustment Counselor can serve as an important role model to a child struggling with excessively rebellious feelings. Most children going through this phase desperately need understanding adults who do not necessarily condone such rebellious behavior, but who understand it and are not too severe in their punishment or strictness.

(c) Home Involvement - If adolescent rebellion has reached a point where it can no longer be handled within the framework of the school setting, it is necessary to contact the parents. Here it is important to help parents see that a reasonable amount of rebellion is characteristic of this age group and that the child should not be restricted or punished excessively.

When it is diagnostically clear that the adolescent rebellion has deeper roots and has become a relatively serious conflict for the child, parents should be encouraged to seek help.

(d) Other Agency Involvement - Depending upon the seriousness of this situation, group work-agencies can be of immense service in helping the rebellious adolescent through tumultuous times. Social agencies can help with parents and will often take the young adolescent into casework treatment. Child guidance facilities are indicated if the problem has deep roots and does not lend itself to the usual ameliorative techniques.

EVALUATION OF THE PROGRAM

The major task in evaluating the school adjustment program is the comparison of the experimental adjustment program with its two distinctive features - a smaller service population and innovations in detection and referral procedures - with the established SAC program involving much larger service populations and differing in referral procedures.

By the end of the demonstration period the evaluation should be able to answer the following questions:

1. Specifically who were exposed to the program (by name, address, age, sex, school performance, and other characteristics)?
2. What procedures and methods were used in the program? To what extent were different procedures used with different individuals? To what extent were the same procedures applied in differing amounts to different individuals?
3. Did those who were exposed to the program change in the direction called for by the objectives of the program?
4. Can those changes, if they did in fact occur, be attributed to the program?

Target Population and Exposure to the Program

This experiment is a comparison of the experimental School Adjustment Counseling Program involving considerably smaller service populations and innovations in detection and referral procedures, with the established School Adjustment Counseling Program involving much larger service populations and different referral procedures.

All the pupils in the experimental and control classes in the experimental school district will be identified by name and address. (The rationale for gathering the same information on control classes will be explained later.) The school records of each pupil will be photographed by ABCD research personnel, and information concerning school performance and attendance of each will be collected throughout the demonstration period. Similar procedures will apply to pupils who enter the experimental schools during the same period. During the demonstration period, data will also be gathered on those children who leave the experimental districts but remain in the Boston Public School System.

The following table gives the number of pupils in each grade of each demonstration school district:

Number of Pupils by School District and Grade in Demonstration Schools
(Experimental and Control Classes Combined)
(1963 - 1964)

	School District				
Grade	E1	E2	E3	JH1	JH2
Kindergarten	175	166	120	-	-
1st	259	250	169	-	-
2nd	193	217	121	-	-
3rd	195	175	145	-	-
4th	175	172	163	-	-
5th	156	148	144	-	-
6th	148	153	105	-	-
7th	-	-	107	185	221
8th	-	-	80	171	219
9th	-	-	-	146	186
Special Classes	60	34	58	-	-

Each individual will be assigned a six-digit numerical code according to procedures established for the ABCD Individual Tracking Center. The numerical code both facilitates the processing of the data and protects the confidentiality of the information pertaining to each pupil. The data on the school records will be coded and punched on IBM cards and stored for access within the ABCD data retrieval system. Information about the characteristics of individuals exposed to the program is essential for identification purposes and to:

a. Select control groups - (comparable populations not exposed to the program) - in order to determine whether changes can be attributed to the program.

b. Determine whether different results are obtained for youth with different characteristics, since the program may not be equally effective for all exposed.

c. Determine whether the effects produced are related to the amount of exposure - it is essential to record the amount of time each individual was exposed to the program.

Program Procedures

In order to answer the second question concerning the procedures used in the program, information will be obtained and kept up-to-date on the following:

1. The number and identity of all pupils referred to each experimental and regular Pupil Adjustment Counselor
2. The sources of each referral
3. The nature of the problems (a) as described in the initial referral, (b) as indicated by the preliminary investigation, and (c) as finally diagnosed by the experimental Pupil Adjustment Counselor
4. Procedures used in making preliminary investigations by experimental Pupil Adjustment Counselor
5. Recommendations made to the experimental Pupil Adjustment Counselor concerning each referral by the supervisor
6. Procedures used in making further investigation, if investigation is recommended and approved
7. Number and nature of contacts with child, parents, teacher, outside agency or other sources for each referral
8. Extent to which recommendations are actually carried out -- by child, parent, teacher, agency, etc.

Evaluation of the Program

A set of reporting forms and observational check lists have been developed cooperatively by ABCD's program and research staff and the Director of the Pupil Adjustment Counseling Program for the Boston Public Schools.

It will be the responsibility of the ABCD Program Specialist, assigned to the School (Pupil) Adjustment Counseling Program, to compare the procedures actually used in the experimental program with the procedures outlined in the program design. Reasonably accurate information as to whether the original design was in fact implemented is essential if unwarranted conclusions from the findings of the action-research demonstration are to be avoided.

If the program is successful, this procedural information will be needed -- not only to continue and expand the program, but also to aid another community or agency interested in establishing a similar program. The procedures which were actually followed are the ones to be repeated. Even if the two sets - the implemented and the designed - are approximately the same, a detailed record of how the program was conducted would be more specific than the design. This detailed record should include the problems that were not foreseen by the program design and how these were handled. If the program is unsuccessful, it may be that the original design was never carried out. It is important that program designs not be rejected if they have in fact not been tried.

Measurement of Desired Changes

To determine whether the pupils exposed to the program changed as desired, instruments will be developed to measure change in terms of the variables related to the objectives of the program. Measurements on each variable must be obtained for each pupil exposed to the program.

The objectives of the Pupil Adjustment Counseling Program will be measured as follows:

1. School Performance - School performance will be measured in terms of three variables:

Measurement of Desired Changes (Cont.)

a. Weighted course grade averages (Each letter grade will be assigned a numerical value which will be averaged.)

b. Scores on standard reading tests administered by ABCD and/or the Boston Public Schools

c. Scores on standard arithmetic tests administered by the Boston Public Schools

2. School Behavior - School behavior will be measured in terms of two variables:

a. Deportment grades as recorded by teachers in the Boston Public Schools

b. Number of days truant as officially recorded at the school attendance office of the Boston Public Schools

Data on each of these variables will be collected for all pupils in the demonstration schools. Change will be measured by comparing pre-program measures with a series of post-program measures. The pre-program measures will be based on information recorded during the school year preceding exposure to the program, or when such information is not available (as in the case of the achievement tests), on the most recent information prior to exposure. The post-program measures will be based on information obtained during the experimental years and during at least one year following termination of exposure to the program.

Measuring the Effects of the Program

To answer the fourth question listed previously - whether changes, if they occur, can be attributed to the program - data on control groups are required to provide an estimate of what changes would have occurred had there been no intervention. Since the Pupil Adjustment Counseling Program involves a comparison of the Experimental Program with the regular Pupil Adjustment Program, pupils eligible for counseling according to the existing procedures properly constitute potential controls. If they are sufficiently similar to the experimental pupils in other respects, their behavior provides an estimate of what would have occurred had there been no experimental Pupil Adjustment Counseling Program.

Evaluation of the Program

There are two innovative features that this design will attempt to assess. The first feature is concerned with a modification of the referral process used in the regular Pupil Adjustment Counseling Program. Currently, the PAC receives all referrals directly from the principal. A change in these referral procedures, to be tried in the experimental program, involves the PAC in working directly with the teachers to assist them in identifying pupils who need the attention of the PAC. The second feature to be evaluated is the effect of reducing the eligible population.

The basic design to be used in the evaluation of the effects of the experimental Pupil Adjustment Program in the three elementary school districts is a modification of the "random allocation of subjects to treatments procedures". The unit to be randomized will be classes rather than individuals. A uniform design will apply to each of the three experimental elementary school districts. A different design will be used to evaluate the junior high school program, which will be discussed later. Two-thirds of the classes in each of the elementary school districts will be randomly assigned to the experimental counselor. The remaining one-third will be assigned to the regular counselor in that district.

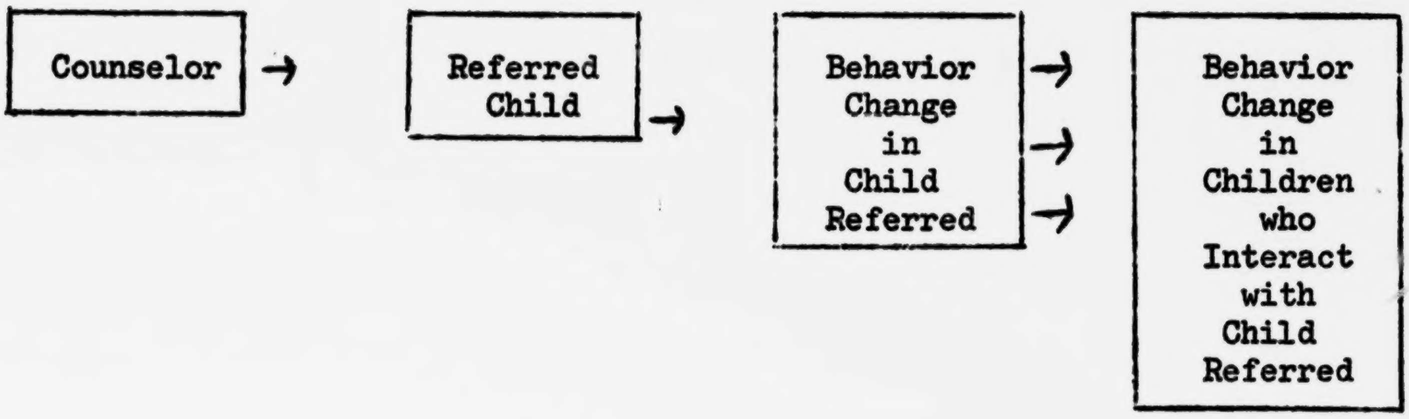
In each demonstration elementary school district the experimental Pupil Adjustment Counselor will be based in the school containing the offices of the district principal. In the base school, referrals to the experimental counselor will be made directly by the teacher (or other school personnel). In addition, the experimental Pupil Adjustment Counselor will work directly with the teachers to help improve the teacher's skills in identifying children in need of special attention. Referrals to the regular Pupil Adjustment Counselor from the remaining classes in that school will be made through the principal, in accordance with existing practices. All referrals in the other schools in the district, whether to the experimental Pupil Adjustment Counselors or to the regular Pupil Adjustment Counselors, will be made through the principal in accordance with existing school adjustment counseling practices.

The above design represents a deviation from the "random allocation of subjects to treatment" design in the following ways:

1. The base schools in each district were not chosen randomly. They are the base schools for the principals of each of the experimental elementary districts. An agreement to try the direct teacher-to-counselor referral procedure was obtained on the condition that those procedures be established only in each principal's base school.
2. For similar reasons, the same schools were designated as the counselors' base schools. Therefore, another variable, greater accessibility to the counselor, has been combined non-randomly with the experimental referral procedure. Estimates of the separate effects of these two program variables cannot be produced by this design.
3. Two special classes were assigned to the experimental counselor by non-random means.

Although the unit of randomization will be the classroom, the basic unit of comparison on the change variables will be the total populations eligible for the services of the experimental Pupil Adjustment Counselor and the regular Pupil Adjustment Counselor.

The basic model is:


Counselor
Referred Child
Behavior Change in Child Referred
Behavior Change in Children who Interact with Child Referred

A different set of procedures will be used in all three elementary school districts for the eight Special Classes (two in one district and three each in the other two). They will be allocated as follows:

> Where there are two Special Classes in one school building, including the base school, they will be randomly allocated as Experimental and Control Classes by toss of a coin. Where there is one Special Class in each of two school buildings, other than the counselor's base school, they will be randomly allocated by toss of a coin. The Special Classes in the remaining schools will be arbitrarily designated as Experimental classes.

The following table lists the number of pupils in the three districts eligible to be referred to the three forms of treatment: eligible for referral directly from the teacher to the Experimental Counselor, eligible for referral through the principal to the Experimental Counselor, or eligible for referral through the principal to the regular Pupil Adjustment Counselor.

Number of Pupils Allocated to Each Treatment by School Grade

(All Three Experimental Elementary Districts Combined)*

Grade	Experimental Counselor Direct Referral	Experimental Counselor Regular Referral	Regular Counselor Regular Referral
Kindergarten	166	174	81
1st	142	277	260
2nd	105	165	263
3rd	248	204	63
4th	168	135	207
5th	119	164	178
6th	157	143	106
Special	38	70	40
	1,143	1,332	1,198

* The 7th and 8th grade children in the K-8 elementary school will be included in the junior high school analysis.

Therefore, the hypothesis to be tested by this model is that through referral the child will receive the service of the Pupil Adjustment Counseling Program, and that this service will improve the performance and behavior in school of the referred child as well as other children in his classroom.

The adoption of this model means that the "measurement of effects" design must attempt to measure the impact of the two programs being compared, experimental and regular, on their respective eligible populations, not just on the children with whom they actually work.

Presently the regular Pupil Adjustment Counselor is responsible for eight elementary school districts. If we assume a population of approximately 1200 students per district, the counselor is responsible for dealing with the problems of children drawn from a total population of 9600 children. Since the experimental counselor will be working in only one school district, he would be responsible for a population of 1200 children. The experimental counselor's total population is further reduced by the research modification of assigning 2/3 to the experimental counselor and 1/3 to the regular counselor. Thus, the total eligible population for the experimental counselor is approximately 800 students in contrast to the total eligible population for the regular counselor, which approximates 8800 students.

It should be noted that not all 8800 nor all 800 are equally in need of the PAC's services. Thus, the actual number of children with problems would be much smaller in both instances. Nevertheless, this hypothetical reduction still leaves the proportional differences between the number of children needing the attention of the experimental and the number needing the attention of the regular Pupil Adjustment Counselor.

The demonstration model being followed in this action-research design tends toward the form shown below --- (the numbers involved are rough estimates for purposes of discussion:

SAMPLE BREAKDOWN OF EIGHT SCHOOL DISTRICTS SERVICED BY
ONE REGULAR AND ONE EXPERIMENTAL P.A.C.

TOTAL OF 8800 ELIGIBLE POPULATION
FOR THE SERVICES OF THE REGULAR P.A.C.

1200	1200
1200	1200
1200	1200
1200	400

TOTAL OF 800 ELIGIBLE
POPULATION FOR SERVICES
OF THE EXPERIMENTAL P.A.C.

800

In the previous chart the experimental counselor has an eligible population of 800 children to work with, all in the same district. The regular counselor has 400 eligible children in that district, plus 8400 other eligible children in seven other school districts.

If we assume that there is a limit to the number of children to whom a counselor can give adequate service, then for purposes of the above example, let us assume that this number is 80 children a year. Under these assumptions, the operational model upon which the experimental counselor may shape his activities can tend toward either of two extreme or polar models:

Model (a): He can work with the same number of children during the same time period as does the regular counselor and, therefore, work with a very different range of problems -- in terms of type and seriousness; or

Model (b): He can work with the same types of problems (in effect, work with the same children that the regular counselor would have worked with had there been no experimental program) and, therefore, be able to devote a much greater amount of time and effort to such children. Consider the following:

Category			
I	Regarded as Most in Need of Attention	10	80 Children in Need of Attention
II	Regarded as Next Most in Need of Attention	15	
III	Regarded as Next Most in Need of Attention	20	
IV	Regarded as Next Most in Need of Attention	35	
V	Regarded as Not in Need of Attention	720	720 Children Not in Need of Attention
		800	Total Population of Children

If this distribution is obtained in each district (in practice, of course, there may be great variations in distributions among school districts), the regular counselor would have eight such districts and could work with only the ten "most-in-need" children in each of his districts (8 x 10 = 80).

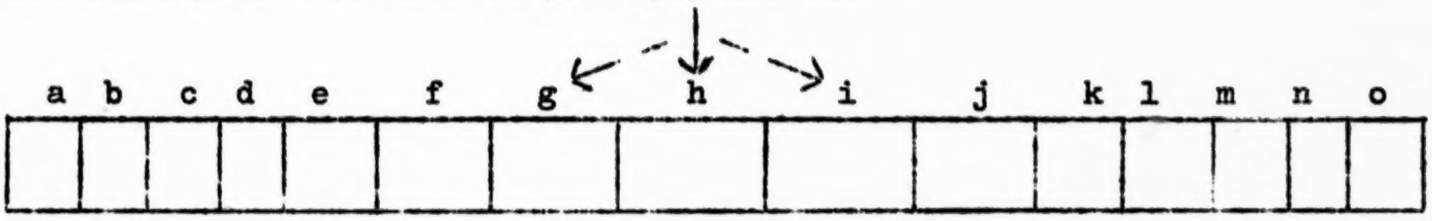
The experimental counselor under Model (a) could work with all 80 "in need" children (Categories I, II, III & IV); under Model (b) he could work intensively with only the 10 "most-in-need" children according to Category I.

We cannot assume, however, that the established referral procedures have selected or will necessarily select those children who "are most-in-need" or have the most serious problems. A valid and reliable seriousness scale or rating device, to check this assumption, may be very difficult to design. What can be assumed, and checked empirically as the demonstration progresses, is that the established procedures tend to focus on particular categories of problems. A more useful model than the vertical strata pattern may be a horizontal spectrum type classification.

In the diagram below, the letters *a* through *o* represent categories of problems such as academic failure, withdrawal, acting out, etc., and the width of the lines indicates the frequency of referral to the PAC. The experimental program may modify the frequency of referral from these categories in several ways:

1. The new referral procedures may alter the pattern of selection by allowing opportunity for proportionately more referrals from the less frequently referred categories.
2. If the regular and experimental counselors' caseloads are composed of similar problem types, the experimental counselor may have the opportunity to work with more cases from the most frequently referred categories.

Under this impact model, effects will occur (a) through working with *different types* of problems, or (b) through working with a greater proportion of the *same types* of problems within a reduced eligible population.



Evaluation of the Program

It will be remembered that there are to be three separate treatment types with corresponding populations that will be evaluated by comparing the effects of each against the others. The three treatments are: 1) regular program in which the counselor uses regular referral procedures, 2) experimental program in which counselor uses regular referral, and 3) experimental program in which counselor uses experimental referral procedures.

The measurement of the relative effects of each of the "treatments" will be made, however, in terms of impact on the academic performance and on the school behavior of the total populations of eligibles for each of the treatments.

There are two assumptions implicit in the program model adopted for this demonstration:

a) The regular counselor will give service to a considerably smaller proportion of the children eligible for his service, while the experimental counselor will provide service to a larger proportion of the children eligible for such service.

b) The average amount of time spent on each child by the regular counselor will be considerably less than that by the experimental counselor.

Records will be kept during the course of the demonstration concerning the number of referrals from each eligible population, and the services provided each referral, in order to check the assumptions noted above and to provide a basis for estimating the relationships between intensity of service and outcome.

EFFECTS OF INTERACTION

There are three kinds of inter-individual interaction effects which may have a bearing on outcome:

1. Interaction effects among pupils within each class -- experimental or control;
2. Interaction effects between pupils eligible for one treatment with pupils eligible for other treatments. For example, siblings may, by the allocation methods utilized, be assigned to different treatments;
3. Interaction effects between pupils assigned to one treatment and pupils assigned to another treatment because of changes in a pupil's classroom assignment.

Type 1 interaction effects are included theoretically by the program model adopted for this demonstration as part of the process by which the program is expected to have an impact on the pupils eligible for service. It is hypothesized that through such interaction effects, the program will have an impact on children who do not become part of the formal referral-to-treatment caseload.

Type 2 interaction effects represent an impurity in the design. When there are interactive effects between pupils assigned to different treatments, the impact each treatment may have is to that extent blurred. These interactive effects are working against the program hypothesis that treatments under the experimental program will have greater impact than those under the regular program. This means that pupils eligible for the regular counseling services will presumably gain more through interaction with pupils eligible for the experimental services than vice versa, and, thus, tend to reduce the differences in impact that would have occurred without the interaction effects. In general, it is reasonable to assume that interaction should be greater among children within same-treatment populations than between different-treatment populations. This suggests that the possible occurrence of these effects would not constitute an important counter-hypothesis to explain positive findings.

Type 3 interaction effects present a more difficult problem, closely related to another problem inherent in this action-research-design, that of the effects of the redistribution of children into classrooms at the beginning of each school year. The adopted administrative principle is: a pupil whose classroom assignment is changed becomes part of the eligible population of the counselor to whom his newly-assigned class has been allocated. If the child has already been referred for counseling service, he will become, according to this principle, a part of the caseload of the "new" counselor. The major reasons for such changes in assignment are likely to be (a) change in residence or (b) assignment to a Special Class. The problems posed by the reassignment of children, at the beginning of each school year, will be encountered more frequently but remain difficult to solve since they result from school policy on promotion and classroom assignment.

These problems, stemming from the three types of interaction effects, appear to involve a combination of two complex variables: (1) duration of eligibility for each treatment, and (2) a contextual variable involving the populations with whom the pupil has interacted, the number and types of referral within each population, the kinds of services the referrals receive, and the amount of change the populations manifest.

A contextual variable is a characteristic of a group representing some aspect of the context within which the members of the group act. The average age of a group is an example of a contextual variable. A number of assumptions will have to be made before attempting to solve this problem:

(a) It will be assumed that only contextual variables pertaining to family populations and classroom populations, of which the individual is or has been a member, can be considered in this analysis. Out-of-school friendship cliques and the like will have to be ignored;

(b) It will be assumed that the effects of the contextual variables will be constant for each member of the group during a given period of time;

(c) It will be assumed that the distribution of children in need of service is random among classes, independent of assignment to treatment.

This assumption is required in order to allow the number of referrals and the amount of service proferred to be used as a measure of "exposure to treatment". Otherwise, the number of referrals from a given classroom, for example, might be assumed to be a measure of "exposure to negative interactive influences".

If a duration index for each individual and a service index for each class are maintained, each time a pupil is assigned to a different class these combined index values would be recorded as an individual characteristic. The service index value recorded would be the value of that index for that class while the individual was a member of that class. The service index values for regular counselor classes should be considerably lower than the values for experimental classes. If they are not, either the regular counselors are devoting a disproportionate amount of their time to their classes in the demonstration districts, or the experimental counselors are not providing more intensive service within their eligible populations.

Pre-program and post-program scores will be computed for each criterion variable -- course grades, reading achievement, arithmetic achievement, deportment, and truancy -- for each child in the experimental and control classes. The post-program score will be calculated for a one-year interval (the experimental year); a score calculated in the same way for the prior year will yield a pre-program score.

A four-way analysis of variance design will be used. The following main effects should supply answers to our hypotheses as to the effect of the various factors:

Effects of Interaction

1. Subject in experimental class with direct referral; experimental class, regular referral; or control class, regular referral
2. Subject counseled or not
3. Subject is a high, medium or low-risk person -- using sets of:
   (a) educational variables
   (b) social variables
   (c) behavioral variables
4. Subject is in another, or combination of other, experimental programs.

This same basic analysis of variance model would be performed six times: once using all the outcome criteria in combination in a multiple-criterion analysis of variance;[1] and once each for the five separate outcome criteria.

The risk scores for Effect 3, which focuses on educational, social, and behavioral variables, would be calculated as follows: for the multiple-variable "educational factor", a series of educational variables such as IQ, reading score, arithmetic score, left-back or not, and course grades will be regressed on the criterion variables; for the multi-variable "social factor", a series of social variables such as census tract of residence, residential mobility, sex, age, number of siblings, race will be regressed on the criterion variables; for the multi-variable "behavioral factor", a series of behavioral variables such as truancy, deportment, police contacts, type of offense, appearance, citizenship grades, court appearance will be regressed on the criterion variables. Separate risk scores for each of the three factors will be computed for each of the five criterion variables and for the criterion variables in combination.[2]

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[1] Methods have recently been developed to analyze multiple-way designs using multiple outcome criteria. CF R. Darrel Bock, "Multivariate Analysis of Variance of Repeated Measures" in C. W. Harris, *Problems in Measuring Change*, Univ. of Wisconsin Press, 1963, pp. 85-103.

[2] The problem of deriving weights for the "behavioral factor" when used against the multiple outcome criteria in combination has not, at this point, been solved. Procedures such as canonical regression and averaging the single criterion beta weights will be explored.

Effects of Interaction

Analysis of Effect 4 focuses on the distribution of subjects among several ABCD programs. Since the ABCD-school programs are concentrated in a few schools, there will be limitations on the extent to which we will be able to separate the effects of the different programs. For example, the Experimental Reading Program is being conducted in the 5th, 6th and 7th grades in the Rice-Franklin District. The Experimental Pupil Adjustment Counselor has been assigned to one or more, but not all, classes in each of the grades, kindergarten through eighth, in that same district. When the children who are in the "control" schools of the reading experiment (children being given reading tests but not exposed to the experimental reading program) are included for analysis, we will have the following categories:

1. Children in the counseling program, but not in the reading program
2. Children in the reading program, but not in the counseling program
3. Children in both programs
4. Children in neither program

(There will be no children in Category 3 who are in kindergarten through the fourth grade or in the eighth grade.)

If a third program, such as Guidance, is added to the analysis, there will be eight logically possible categories of subjects.

In order to separate to some degree the possible differences in the operation of these factors over grades, two four-way analyses will be made for each criterion variable and for each set of risk scores: one for grades one through three, the other for grades four through six. Sample size and the capacity of available computers prohibit separate analyses for each grade or a five-way analysis with grade as a factor. Even with the four-way design, approximately 3500 subjects will be distributed over 288 cells.

The junior high Pupil Adjustment Counseling Program is in one of the Experimental Reading junior high schools (seventh grade only). Since we were unable to randomize classes to the experimental and regular Pupil Adjustment Counselors in the junior high school program, seventh grade subjects will fall into all four categories above.

Effects of Interaction

There would be six double interactions. The most relevant question seems to be: Does the effect of counseling depend on whether the subject is in an experimental classroom? Assuming we equated the cells by adjustment, if we found significant classroom and counseling effects with no interaction, we will have substantiated a diffusion effect. To see this, look at the following two-dimensional slice of the four-way design:

CLASSROOM

	Exp. (direct)[1]	Exp. (regular)[1]	Control (regular)
Counseled	Hi[2]	Hi	Med
Not Counseled	Med	Med	Lo

On the other hand, if no diffusion takes place, we might expect the following type of table:

CLASSROOM

	Exp. (direct)[1]	Exp. (regular)[1]	Control (regular)
Counseled	Hi	Hi	Med
Not Counseled	Lo	Lo	Lo

We might expect interaction here. By inspecting the nature of the mean differences producing interactions, we may gain information about the character of the diffusion effect or the lack of it.

1/ Direct or regular referral system

2/ Scores on criterion variable

Effects of the Interaction

Other important interactions to look at are - risk by whether counseled or not and risk by school classroom which test the hypotheses that:

1. The effects of counseling do not depend on the student's risk score

2. The effects of being in one of the three types of classes do not depend on risk score

There are, of course, other interesting interactions (e.g. between other experimental programs and type of referral). However, computer capacity will limit the number of interactions which are testable.

Control Group Procedures for the Experimental Junior High School

Randomization of classes in the Lewis Junior High School is not feasible. Allocation of two-thirds of the classes to the experimental counselor would result in a much smaller eligible population for the services of the experimental counselor than called for by the program design. A proportion larger than two-thirds would not provide a sufficient number of control classes; therefore, a different procedure will be used in the junior high school component of this Pupil Adjustment Counseling design to provide an estimate of what the behavior of the experimental pupils would have been without the services of the experimental counselor.

Since the control of variables possibly related to the outcome variables cannot be handled by a random allocation to "treatments" procedure, some form of statistical control must be applied to populations already allocated.

The procedure adopted for the evaluation of the effects of the junior high school counseling program is a modified version of the procedures used for the program in the elementary schools. A statistical device known as the analysis of covariance will be applied to the data produced by the action-research demonstration.

Control Group Procedures for the Experimental Junior High School

A similar junior high school will be selected as the control school. This school will not be exactly equivalent to the experimental school; however, the covariance adjustment of the criterion measures will "wash out" any differences.[1]

Due to the smaller number of subjects involved, we will not be able to test as many effects as in the elementary school design. The best compromise appears to be a three-way 3 x 2 x 2 design:

Program	-- experimental (direct), experimental (regular); control (regular)
Counseled	-- subject received counseling or not
Grade	-- seventh or eighth

This yields 12 cells among which the experimental and control subjects will be distributed.

The above design has the advantage of being the closest possible parallel to the elementary school design, given the limitations of selection and size of sample.

1/ For one very clear discussion of the analysis of covariance procedures, see E. F. Lindquist, Design and Analysis of Experiments in Psychology and Education, Boston, Houghton Mifflin Co., pp. 317-339.

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